Medical and Dental History

TODAY'S DATE: ____/____/____

Charles E. Montoure, DDS, MS
Mark H. Hanson, DDS, MS

PATIENT:			SEX: ☐ M ☐ F	AGE:	DATE OF BIRTH: / /
HOME PH:	WORK PH :	CELL PH:	EMPLOYER:		SPOUSE:

IF PATIENT IS A MINOR

SCHOOL:		GRADE:	HOBBIES:	
MOTHER:	EMPLOYER:	WORK PH:	CELL PH:	
FATHER:	EMPLOYER:	WORK PH:	CELL PH:	
STEP-MOTHER:	EMPLOYER:	WORK PH:	CELL PH:	
STEP-FATHER:	EMPLOYER:	WORK PH:	CELL PH:	

NAMES OF FAMILY MEMBERS TREATED AT THIS OFFICE:	HOW DID YOU HEAR ABOUT US?
GENERAL DENTIST:	DENTIST PH:
PHYSICIAN:	PHYSICIAN PH:
HISTORY OF ILLNESS OR INJURY:	PRESENT HEALTH:

PLEASE ANSWER THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE:	YES	NO	IF YES, PLEASE EXPLAIN:
Is the patient under a physician's care?	☐	☐	
Is the patient taking any medication?	☐	☐	
Is the patient allergic to any medication / latex?	☐	☐	
Is the patient bothered by allergies?	☐	☐	
Does the patient require antibiotics prior to dental procedures?	☐	☐	
Has the patient ever been exposed to:	☐ Hepatitis	☐ Tuberculosis	☐ HIV

PLEASE INDICATE ANY HISTORY OF THE FOLLOWING CONDITIONS:

- ☐ Artificial Joint
- ☐ Rheumatic fever
- ☐ Heart trouble
- ☐ Abnormal blood pressure
- ☐ Abnormal bleeding
- ☐ Asthma
- ☐ Arthritis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Seizures
- ☐ Tumor
- ☐ Endocrine disorders
- ☐ Blood disorders
- ☐ Bone disorders
- ☐ Nerve disorders
- ☐ Muscle disorders
- ☐ Emotional disorders

- ☐ Clicking, popping or grinding noises in the jaw joints
- ☐ Discomfort in the jaw joints
- ☐ Locking or limited movement of the jaw joints
- ☐ Jaw muscle discomfort
- ☐ Frequent headaches
- ☐ Trauma to the head or face
- ☐ Gum tissue problems
- ☐ Finger/thumb sucking
- ☐ Tonsils and/or adenoids removed

YES	NO	
☐	☐	Does the patient brush regularly?
☐	☐	Does the patient floss regularly?
☐	☐	Does the patient have regular dental check-ups?
☐	☐	Females - are you pregnant?

EXPLAIN ANY OF THE CONDITIONS INDICATED ABOVE / LIST ADDITIONAL MEDICATIONS:

EXPLAIN ANY MEDICAL CONDITIONS NOT INDICATED ABOVE:

REASON FOR ORTHODONTIC CONSULTATION:

ALTERNATE EMERGENCY CONTACT:	PHONE:	RELATIONSHIP TO PATIENT:

To the best of my knowledge, the above information is correct. I will inform the orthodontist of any changes.

Signature of Patient or Parent/Guardian_____ Date____/____/____