James P. Ziuchkovski, DDS, MS, PC

We are excited to welcome you into our practice. The information on the front and back of this form helps us provide you with the best possible orthodontic service. Please make it as complete and accurate as possible. For parents/guardians of children, complete this information for your child. If you have any questions, we would be happy to assist you.

Patient Name:_____ Family Dentist:_____ Date:_____

Dental History

Why are you seeking an orthodontic evaluation? What is your primary concern?

_____

Yes	No	
☐	☐	Do you see a general dentist on a regular basis? Approximate date of last dental check-up: _____
☐	☐	Has the patient had a severe head or face injury? Explain: _____
☐	☐	Has the patient had any injuries to the teeth? Explain: _____
☐	☐	Does the patient have a history of thumb or finger sucking? Stopped? _____
☐	☐	Any history of excessive mouth breathing, snoring, breathing difficulty, or speech problems?_____
☐	☐	Any difficulty encountered in chewing or jaw opening?_____
☐	☐	Any history of "dead teeth" or root canals treated?_____
☐	☐	Any history of periodontal or "gum problems"?_____
☐	☐	Any history of "gum boils" or frequent canker/cold sores?_____
☐	☐	Is the patient self conscious about his/her teeth? Explain:_____
☐	☐	Is the patient aware or concerned about an under or over developed jaw? Explain:_____
☐	☐	Has the patient consulted an orthodontist previously? _____
☐	☐	Has the patient had any previous orthodontic treatment? Describe:_____
☐	☐	Has the patient had any serious trouble associated with any previous dental treatment?_____
☐	☐	Does the patient brush/floss conscientiously?_____

Please Check if there is a History of:

☐ Clenching Teeth ☐ Grinding Teeth ☐ Jaw Joint Soreness ☐ Jaw Joint Clicking ☐ Jaw Joint Locking
☐ Muscular Soreness around Head and Neck ☐ Headaches (more than normal) ☐ Ringing in the Ears

Is there any other information that may be helpful?_____
_____

Growth Information for Patients Under 16 Years of Age:

Father's Height: _____ Mother's Height: _____ Adopted ☐ Yes ☐ No
Patient Resembles: ☐ Neither Parent ☐ Mother ☐ Father
Is there any history of underbite (Class III occlusion) in the family? ☐ No ☐ Yes Who?_____
Girls: Has she started menstruation? ☐ No ☐ Yes When?_____
Boys: Has his voice changed? ☐ No ☐ Yes When?_____

School Patient Attends: _____

Name and Ages of Patient's Brothers and Sisters: _____

Patient's interest or hobbies: _____

Medical History **Patient Name:**_____

	Yes	No	
Is the patient in good health?	☐	☐	Reason: _____
Any major or unusual illnesses?	☐	☐	Explain: _____
Currently under physician's care?	☐	☐	Name and Phone #:_____
Currently taking medication?	☐	☐	List:_____
Allergies	☐	☐	List:_____
Drug Sensitivity	☐	☐	List:_____
Has patient ever been hospitalized?	☐	☐	If so, for what? _____

Please Check if Patient Has or Had Any of the Following:

Yes	No		Yes	No	
☐	☐	Heart murmur or other heart conditions	☐	☐	Rheumatic Fever
☐	☐	High Blood Pressure, or other cardiovascular problems	☐	☐	Epilepsy or seizures
☐	☐	Require antibiotic prophylaxis for dental procedures	☐	☐	Bone Disorders
☐	☐	Blood Disease or prolonged bleeding	☐	☐	Diabetes
☐	☐	Anemia (including Sickle Cell Anemia)	☐	☐	Endocrine Problems
☐	☐	Birth defects or heredity problems	☐	☐	Herpes (Cold Sores)
☐	☐	Liver disease, jaundice or hepatitis	☐	☐	Tuberculosis
☐	☐	Infectious diseases such as HIV, AIDS, or Heb B/C	☐	☐	Asthma
☐	☐	Cancer, tumor or radiation therapy	☐	☐	Frequent Colds/Flu
☐	☐	Ever taken oral or IV bisphosphonates	☐	☐	Chew or smoke tobacco?
☐	☐	Currently pregnant?	☐	☐	Tonsils Removed: Age:
			☐	☐	Adenoids Removed: Age:

Are there any other medical conditions or additional information that we should be aware of?

_____

_____

_____

To the best of my knowledge, I have answered the medical and dental questions completely and accurately.

Signature of patient or parent/legal guardian (if minor):_____Date_____

_____(Printed)

MEDICAL HISTORY UPDATE (for office use)

Please review the medical and dental history information on the front and back side of this form.

Does the patient still see the same family dentist? YES ☐ NO ☐
If "No," who is the patient's current dentist? _____

Does the patient still see the same primary care physician? YES ☐ NO ☐
If "No," who is the patient's current physician? _____

Are there any changes in the patient's medical or dental condition since this form was last completed?
YES ☐ NO ☐ If "YES," please describe all changes below:

_____

_____

Signature of patient or parent/legal guardian (if minor):_____Date_____