Bedford Orthodontics

Orthodontics for children and adults

MEDICAL HISTORY

Date of Last Physical Exam: _____ Name of Physician_____

Is patient currently under the care of a physician? **Yes** **No** If **Yes**, please explain: _____
Has patient been hospitalized in the past 5 years? **Yes** **No** If **Yes**, please explain: _____
Is patient currently taking any medications? **Yes** **No** If **Yes**, please list:

_____

Has patientôs tonsils or adenoids been removed? **Yes** **No** If **Yes**, please explain: _____

Height of Patientôs Father: _____ Height of Patientôs Mother: _____

Does the patients have (or had) any of the following (**Please Circle**):

Yes **No** Heart Problems/Disease
Yes **No** Heart Murmur
Yes **No** High Blood Pressure
Yes **No** Low Blood Pressure
Yes **No** Stroke/Circulatory Problems
Yes **No** Bleeding Problems/Hemophilia
Yes **No** Anemia
Yes **No** Pacemaker
Yes **No** Nervous System Problems
Yes **No** Epilepsy/Seizures
Yes **No** Musculoskeletal Disorders
Yes **No** Allergies to Medications
Other Allergies_____
Yes **No** Measles
Yes **No** Mumps
Yes **No** Rheumatic Fever
Yes **No** Scarlet Fever
Yes **No** Tuberculosis

Yes **No** Arthritis/Joint Problems
Yes **No** Asthma
Yes **No** Typhoid Fever
Yes **No** Diabetes
Yes **No** Ulcers/Reflux
Yes **No** Hepatitis
Yes **No** AIDS/Positive HIV
Yes **No** Sexually Transmitted Diseases
Yes **No** Malignancies/Cancer
Yes **No** Osteoporosis/Bone Problems
Yes **No** Artificial Joints/Transplants
Yes **No** Liver Problems/Disease
Yes **No** Speech Problems
Yes **No** Sinus Problems
Yes **No** Psychiatric Treatment
Yes **No** Tonsillitis
Yes **No** **Women** ï Are you Pregnant?

Are there any medical conditions that we should be aware of? _____

_____

_____

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

RICHARD M. HESBY, D.D.S., M.S.
55 NORTH ROAD, SUITE 215 BEDFORD, MA 01730
T 781.275.0575 F 781.275.0577

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DENTAL HISTORY

Reason for visit? (i.e., referred by dentist, crowding, appearance etc.)_____
_____

Name of Family Dentist: _____ Did he/she refer you to our office?	**Yes**	**No**
Date of most recent dental exam: _____		
Was a panoramic x-ray taken at this time?	**Yes**	**No**
Has the patient previously been seen by another orthodontist, or had any prior orthodontic treatment?	**Yes**	**No**
If yes, please describe: _____		
Any problems with previous dental or orthodontic treatment?	**Yes**	**No**
If Yes, please explain:_____		
Does anyone else in your family have a similar dental need?	**Yes**	**No**
If yes, please describe: _____		
Does the patient have difficulty breathing through his/her nose?	**Yes**	**No**
Has the patientôs physician prescribed antibiotics before dental procedures?	**Yes**	**No**
If Yes, please explain:		
_____		

Is the patient aware of any of the following conditions?

Clenching or grinding teeth?	**Yes**	**No**
Clicking, popping or grating noise in your jaw joint?	**Yes**	**No**
With pain?	**Yes**	**No**
How long? _____		
Discomfort, tightness or spasms of facial or neck muscles?	**Yes**	**No**
Catching or locking of jaw?	**Yes**	**No**
Periodontal disease or bleeding gums?	**Yes**	**No**
Has patient ever injured neck, head or jaw?	**Yes**	**No**
Has patient ever injured or damaged any teeth?	**Yes**	**No**
Was there any thumb or finger sucking?	**Yes**	**No**
Until what age? _____		

I affirm that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in medical status. I understand that Orthodontics is a dental specialty dealing with the alignment of the teeth and jaw, and is different from General Dentistry. I also understand that good oral hygiene and regular visits at a minimum of every 6 months to my General Dentist are critical to maintaining dental health before, during and after orthodontic treatment.

_____ _____

Signature of Patient or Guardian (if patient is a minor) **Date**

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