OCEAN'S EDGE ORTHODONTICS
Dr. F. Edward Murdoch

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Personal Information and Health History Form

Patient's Name:____ Date: ___________________________
Email:____ Birthdate:____________________
Patient Medical Information **Medical Doctor: Dr.** ____
Are you in good health? **Y / N** **Women**: Are you pregnant? **Y / N** **Due Date:** ___________________
Are you currently being treated by a doctor for any illness? **Y /N** **Explain:** _____________________________________
____
Current Medications:____

Summary of Medical History: please check boxes if you have, or have had any of the following:

AIDS/HIV		Chemotherapy		Heart Murmur		Mental Disorders		Smoke / Tobacco	
Anemia		Congenital Heart Defects		Heart Problems		Nervous Disorders		Stomach Problems	
Arthritis		Diabetes		Hepatitis A / B / C		Pacemaker		Stroke	
Artificial Joints		Dizziness/Fainting		Herpes		Pneumonia		Tonsilitis/ Adenitis	
Asthma		Drug Allergies/Sensitivities		High Blood Pressure		Prolonged Bleeding		Tuberculosis	
Blood Disorders		Epilepsy		Kidney Disease		Radiation Treatment		Tumors	
Bone Disorders		Glaucoma		Latex Allergy/Sensitivity		Rheumatic Fever		Ulcers	
Cancer		Heart Disease		Liver Disease		Seasonal Allergies		Other:_______	

History of Major Illness (not listed above): ____
Additional Comments:____

Patient Dental History: **Dentist: Dr.**____________________________ **Last dental examination:**____________
Do you have any current dental problems: **Y / N** **Explain**: ____
Have you ever had complications during or following dental treatment? **Y / N**
If yes: Did you require emergency care or hospitalization? **Y / N**

Summary of Dental History: please check boxes if you have, or have had any of the following signs, symptoms, or habits:

Sensitive teeth		Mouth odours / bad tastes		Severe head / facial injuries		Chewing ice cubes	
Bleeding / sore gums		Food caught between teeth		Thumb /finger sucking		Clenching / Grinding	
Loose adult teeth		Clicking or popping in jaw		Mouth breathing		Unable to open wide or move jaw	
Change in bite		Headaches		Pen biting		Pain in jaw	
				Fingernail biting		Chewing problem	

Are you happy with the appearance of your teeth? **Y / N**
Have you consulted or been treated by an orthodontist previously? **Y / N**
Have you ever had your bite adjusted? **Y / N**
Have you ever had a bite plate or other oral appliance? **Y / N**
Have you ever consulted or been treated by a Periodontist? **Y / N**
Have you ever been treated for jaw or joint problems? **Y / N**
Is it important to you that you keep your teeth throughout your lifetime? **Y / N**
Have you ever had an upsetting experience with dental treatment? **Y / N**
Are you nervous about undergoing dental treatment? **Y / N**
Have you ever been informed of missing teeth or teeth that did not form? **Y / N**

☐ **To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.**

☐ **I consent to the use of my orthodontic records (eg. Dental x-rays, photographs, and plaster models) for orthodontic consultations, educational and research purposes (eg. Lectures and study clubs), and in our office "before and after" book.**

___________________________________ ___________________________

Signature of Patient / Parent / Guardian **Date**