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Dr. Paul Ouellette, D.D.S., M.S. A.B.O.
Orthodontics for Children and Adults
PATIENT HISTORY

Name of Patient: _____ Age _____ Date of Birth _____ Office _____

MEDICAL HISTORY – Please answer each question. **Circle Yes or No** Physician: _____ Tel#: _____

- Yes No Are you in good health at the present time? If not, describe _____
- Yes No Are you presently under the care of a physician for some illness or disease?
- Yes No Have you been hospitalized or had a serious illness in the last 3 years? Describe _____
- Yes No Do you have a bleeding tendency or slow healing of wounds?
- Yes No Are you allergic to or had a reaction to any drugs or medications? Name the Drugs? _____
- Yes No Have you ever had a reaction to a dental injection or anesthetic? Allergic to Latex? Yes No
- Yes No **(WOMEN ONLY)** Are you pregnant? How many months? _____ Due Date: _____
- Yes No Are there any other medical or dental problems we should know about? Please list below.
- Yes No Do you smoke or use tobacco products? If Yes, for how long? _____

Describe below or attach another page to tell us about any medical conditions not listed on this form.

Do you have or have you ever had any of the following? (Please check appropriate conditions) Other _____

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma / Hay Fever | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Nervous Condition | <input type="checkbox"/> Fainting Spells / Seizures | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Venereal Disease /HIV/AIDS | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> Arthritis / Gout |

DENTAL HISTORY – Please answer all questions. Circle Yes or No

- Yes No Have you ever had a bad dental experience or are you nervous when visiting the dentist?
- Yes No Do your gums ever bleed or feel sore?
- Yes No Do any of your teeth feel loose?
- Yes No Have you noticed your teeth shifting or have you noticed a change in your bite?
- Yes No Have you ever had any periodontal treatments and/or surgery related to your gums?
- Yes No Do you have frequent or chronic headaches? Pain in your jaw joints?
- Yes No Do your jaws ever click or pop when chewing or opening? Describe _____
- Yes No Have you ever had difficulty in opening or closing your jaw or has it ever locked?
- Yes No Do you clench your teeth during the day or do you grind your teeth at night?
- Yes No Do you ever have earaches, ringing in the ears, or feel dizzy?
- Yes No Are any of your teeth sensitive to hot or cold foods or drinks?
- Yes No Do you ever get food packed in between in your teeth?
- Yes No Do you have difficulty flossing between any teeth?
- Yes No Are you unable to eat any foods because of your teeth?
- Yes No Do you have crooked teeth OR do you feel that your teeth stick out too far?
- Yes No Do you have spaces between your teeth that you don't like?
- Yes No Are you happy with the color of your teeth?
- Yes No Do you like the shape and size of your teeth?
- Yes No Are you comfortable with the way your teeth fit together?
- Yes No Do you have old fillings or dental work that doesn't look good when you smile?
- Yes No Are you current with your family dentist and/or other dental specialists (ie.Periodontist)

Your Dentist's Name: _____ Other Dental Specialist(s): _____

What would you like to change the most in the appearance of you teeth? _____

It is the patient's responsibility to inform our office of any changes in their medical condition. Initials _____

Describe below or attach another page to tell us about any dental conditions not listed on this form. Thank you! Dr. O

Patient (or Guardian's) Signature _____ Date _____