Merrimack Valley Orthodontics

Joseph P. Giordano, DMD - Audra B. Reynoso, DMD

Today's Date: ____/____/ ______

Patient Name: (First)________________________________ (M)__________ (Last)________________________________ Sex: Male / Female

Nickname: _________________________ DOB: ___ / ___ / _______ Age: ______ Phone #s (Check Best): ( )________________ ( ) _______________

DENTAL HISTORY

Why are you interested in orthodontic treatment? ____

____

General Dentist ____Date of last dental care ________________________

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐No

Have you ever experienced an injury to the face, mouth, teeth or chin? ☐ Yes ☐No

Current or past habits/problems affecting the mouth or teeth? ☐ Thumb/finger sucking ☐ Nail biting ☐Clenching/grinding teeth

☐ Lip sucking/biting ☐Mouth breather ☐Tongue thrust ☐Jaw Joint pain/discomfort Other________________________________

Do you have any speech problems? ☐ Yes ☐ No

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Other information about your dental health or previous treatment____

Has your physician recommended pre-medication with antibiotics before dental treatment? ☐ Yes ☐ No

MEDICAL HISTORY

Physician's Name: ____ Phone #: ____________________________Date of last visit: ___________

Have you had any serious illnesses or operations? ☐ Yes ☐No If yes, describe ____

Are you currently under physician care? ☐ Yes ☐No If yes, describe ____

Have you ever had a blood transfusion? ☐ Yes ☐No If yes, give approximate dates ______________________________________

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you had any of the following?

☐ Y ☐ N AIDS/HIV Positive
☐ Y ☐ N Anaphylaxis
☐ Y ☐ N Anemia
☐ Y ☐ N Arthritis,Rheumatism
☐ Y ☐ N Artificial heart valves
☐ Y ☐ N Artificial joints
☐ Y ☐ N Asthma
☐ Y ☐ N Atopic (allergy prone)
☐ Y ☐ N Back problems
☐ Y ☐ N Blood disease
☐ Y ☐ N Cancer
☐ Y ☐ N Chemical Dependency
☐ Y ☐ N Circulatory problems
☐ Y ☐ N Cortisone treatments
☐ Y ☐ N Cough, persistent
☐ Y ☐ N Cough up blood

☐ Y ☐ N Diabetes
☐Y ☐ N Epilepsy
☐ Y ☐ N Fainting
☐ Y ☐ N Food allergies
☐ Y ☐ N Glaucoma
☐ Y ☐ N Headaches
☐ Y ☐ N Heart murmur
☐ Y ☐ N Heart problems
☐ Y ☐ N Hearing impairment
☐ Y ☐ N Hemophilia/Abnormal bleeding
☐ Y ☐ N Herpes
☐ Y ☐ N Hepatitis
☐ Y ☐ N High blood pressure
☐ Y ☐ N Jaw pain
☐ Y ☐ N Kidney disease or malfunction

☐ Y ☐ N Liver disease
☐ Y ☐ N Material allergies (latex, wool, metal, chemicals)
☐ Y ☐ N Mitral valve prolapse
☐ Y ☐ N Nervous problems
☐ Y ☐ N Pacemaker/Heart surgery
☐ Y ☐ N Psychiatric care
☐ Y ☐ N Rapid weight gain or loss
☐ Y ☐ N Respiratory disease
☐ Y ☐ N Rheumatic/ Scarlet fever
☐ Y ☐ N Shingles
☐ Y ☐ N Shortness of breath

☐ Y ☐ N Sinus problems
☐ Y ☐ N Skin rash
☐ Y ☐ N Spina Bifida
☐ Y ☐ N Stroke
☐ Y ☐ N Surgical implant
☐ Y ☐ N Swelling of feet or ankles
☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Tobacco habit
☐ Y ☐ N Tonsillitis
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Venereal disease
☐ Y ☐ N Other_____

Please describe any Yes answers and
discuss any additional medical conditions that you have had: ____

Please list any medications you are currently taking: ____

Please list all drugs that you are allergic to: ____

AUTHORIZATION

I understand that the information that I have given on this questionnaire is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence and used by the orthodontist to help determine appropriate and healthful orthodontic treatment. It is my responsibility to inform this office of any change in my status.

Signature ____ Date: ___________________________________