McColm Orthodontics
Shelly L. McColm, D.D.S., P.A.
2210 Yale Rd.
Lawrence, KS 66049
(785) 832- 0809
www.mccolmorthodontics.com

MEDICAL / DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

PLEASE COMPLETE THIS FORM AND BRING IT TO THE APPOINTMENT.

Date: _____

PATIENT INFORMATION

Patient's Full Name: _____ I prefer to be called: _____

Phones: Home: _____ Patient's Cell: _____ Gender: _____

Address: _____
Street City State Zipcode

Birth date: _____ Age: _____ Grade: _____ School: _____

No. of Brothers & Sisters: ____ Ages: _____ Family members treated here: _____

PARENT(S) OR GUARDIAN(S) & RESPONSIBLE PARTY INFORMATION – LIST EACH PERSON SEPARATELY

Name: _____ Marital Status: _____ Relationship to Patient: _____

Address: _____
Street City State Zipcode

Phones: Home: _____ Cell: _____ Work: _____ Birth date: _____

Employed By: _____ # Years Employed: _____

Is this person financially responsible for the patient's treatment? ☐Yes ☐No E-mail : _____

Name: _____ Marital Status: _____ Relationship to Patient: _____

Address: _____
Street City State Zipcode

Phones: Home: _____ Cell: _____ Work: _____ Birth date: _____

Employed By: _____ # Years Employed: _____

Is this person financially responsible for the patient's treatment? ☐Yes ☐No E-mail: _____

Name: _____ Marital Status: _____ Relationship to Patient: _____

Address: _____
Street City State Zipcode

Phones: Home: _____ Cell/pager: _____ Work: _____ Birth date: _____

Employed By: _____ # Years Employed: _____

Is this person financially responsible for the patient's treatment? ☐Yes ☐No E-mail: _____

INSURANCE INFORMATION

Insurance Coverage for Ortho Treatment? ☐Yes ☐No Insurance Co.: _____

Primary Policyholder: _____ ID # or S.S.N.: _____ Group No.: _____

Birth date: _____ Employed By: _____

Secondary Policyholder: _____ ID # or S.S.N.: _____ Birth date: _____

Insurance Company: _____ Group No.: _____

Employed By: _____ Work Phone: _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Last revised: 9/10/2024

Name of Patient's General Dentist: _____ Phone No.: _____

Address: _____
Street City State Zipcode

Date Last Seen: _____ Reason: _____

Name of Patient's Physician(s): _____ Phone No.: _____

Address: _____
Street City State Zipcode

Date Last Seen: _____ Reason: _____

For the following questions mark YES, NO, or DON'T KNOW/UNDERSTAND (DK/U). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

☐ yes ☐ no ☐ dk/u Does patient follow directions well?

☐ yes ☐ no ☐ dk/u Does patient brush his/her teeth conscientiously?

☐ yes ☐ no ☐ dk/u Does patient have learning disabilities or need extra help with instructions?

☐ yes ☐ no ☐ dk/u Is patient sensitive or self-conscious about teeth?

MEDICAL PROFILE

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Birth defects or hereditary problems?

☐ yes ☐ no ☐ dk/u Bone fractures or any major accidents?

☐ yes ☐ no ☐ dk/u Rheumatoid or arthritic conditions?

☐ yes ☐ no ☐ dk/u Endocrine or thyroid problems?

☐ yes ☐ no ☐ dk/u Kidney problems?

☐ yes ☐ no ☐ dk/u Diabetes?

☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?

☐ yes ☐ no ☐ dk/u Stomach ulcer or hyperacidity?

☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?

☐ yes ☐ no ☐ dk/u Problems of the immune system?

☐ yes ☐ no ☐ dk/u HIV positive or AIDS?

☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or liver problems?

☐ yes ☐ no ☐ dk/u Fainting spells, seizures, epilepsy or neurological problems?

☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?

☐ yes ☐ no ☐ dk/u Vision, hearing, tasting or speech difficulties?

☐ yes ☐ no ☐ dk/u Loss of weight recently, poor appetite?

☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?

☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

☐ yes ☐ no ☐ dk/u High or low blood pressure?

☐ yes ☐ no ☐ dk/u Tired easily?

☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath or swelling ankles?

☐ yes ☐ no ☐ dk/u Cardiovascular problem (heart trouble, heart attack angina, coronary insufficiency, arterio-sclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

☐ yes ☐ no ☐ dk/u Skin disorder?

☐ yes ☐ no ☐ dk/u Does the patient eat a well-balanced diet?

☐ yes ☐ no ☐ dk/u Frequent headaches, colds or sore throats?

☐ yes ☐ no ☐ dk/u Ear, eye, nose or throat condition?

☐ yes ☐ no ☐ dk/u Hay fever, asthma, sinus trouble or hives?

☐ yes ☐ no ☐ dk/u Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

☐ yes ☐ no ☐ dk/u Local anesthetics (Novocaine or Lidocaine)

☐ yes ☐ no ☐ dk/u Aspirin

☐ yes ☐ no ☐ dk/u Ibuprofen (Motrin, Advil)

☐ yes ☐ no ☐ dk/u Penicillin or other antibiotics

☐ yes ☐ no ☐ dk/u Sulfa drugs

☐ yes ☐ no ☐ dk/u Codeine or other narcotics

☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)

☐ yes ☐ no ☐ dk/u Vinyl

☐ yes ☐ no ☐ dk/u Acrylic

☐ yes ☐ no ☐ dk/u Animals

☐ yes ☐ no ☐ dk/u Foods (specify) _____

☐ yes ☐ no ☐ dk/u Other substances (specify) _____

☐ yes ☐ no ☐ dk/u Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

☐ yes ☐ no ☐ dk/u Does the patient currently have or ever had a substance abuse problem?

☐ yes ☐ no ☐ dk/u Does the patient chew or smoke tobacco?

☐ yes ☐ no ☐ dk/u Operations? Describe: _____

_____

☐ yes ☐ no ☐ dk/u Hospitalized? Describe: _____

☐ yes ☐ no ☐ dk/u Other physical problems or symptoms?
Describe: _____

☐ yes ☐ no ☐ dk/u Being treated by another health care professional? For: _____

Date of most recent physical exam: _____

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

GIRLS ONLY

☐ yes ☐ no ☐ dk/u Has the patient started menstruating? If so, when? _____

☐ yes ☐ no ☐ dk/u Is the patient pregnant?

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, explain.

Bleeding disorders: _____

Diabetes: _____

Arthritis: _____

Metabolic disturbances: _____

Severe allergies: _____

Unusual dental problems: _____

Jaw size imbalance: _____

Any other family medical conditions that we should know about?

DENTAL HISTORY

Now or in the past, has the patient had:

☐ yes ☐ no ☐ dk/u Started teething very early or late?

☐ yes ☐ no ☐ dk/u Primary (baby) teeth removed that were not loose?

☐ yes ☐ no ☐ dk/u Permanent or "extra" (supernumerary) teeth removed?

☐ yes ☐ no ☐ dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

☐ yes ☐ no ☐ dk/u Teeth sensitive to hot or cold; teeth throb or ache?

☐ yes ☐ no ☐ dk/u Jaw fractures, cysts or mouth infections?

☐ yes ☐ no ☐ dk/u "Dead teeth" or root canals treated?

☐ yes ☐ no ☐ dk/u Bleeding gums, bad taste or mouth odor?

☐ yes ☐ no ☐ dk/u Periodontal "gum problems"?

☐ yes ☐ no ☐ dk/u Food impaction between teeth?

☐ yes ☐ no ☐ dk/u Thumb, finger, or sucking habit? Until what age? ____

☐ yes ☐ no ☐ dk/u Abnormal swallowing habit (tongue thrusting)?

☐ yes ☐ no ☐ dk/u History of speech problems?

☐ yes ☐ no ☐ dk/u Mouth breathing habit, snoring or difficulty in breathing?

☐ yes ☐ no ☐ dk/u Tooth grinding or jaw clenching?

☐ yes ☐ no ☐ dk/u Any pain in jaw or ringing in the ears?

☐ yes ☐ no ☐ dk/u Any pain or soreness in the muscles of the face or around the ears?

☐ yes ☐ no ☐ dk/u Difficulty encountered in chewing or jaw opening?

☐ yes ☐ no ☐ dk/u Aware of loose, broken or missing restorations (fillings)?

☐ yes ☐ no ☐ dk/u Any teeth irritating cheek, lip, tongue or palate?

☐ yes ☐ no ☐ dk/u Concerned about spaced, crooked or protruding teeth?

☐ yes ☐ no ☐ dk/u Are you aware or concerned about under- or over-developed jaw?

☐ yes ☐ no ☐ dk/u "Gum boils", frequent canker sores or cold sores?

☐ yes ☐ no ☐ dk/u Taking any form of fluoride?

☐ yes ☐ no ☐ dk/u Any relative with similar tooth or jaw relationships?

☐ yes ☐ no ☐ dk/u Had periodontal (gum) treatment?

☐ yes ☐ no ☐ dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

☐ yes ☐ no ☐ dk/u Any serious trouble associated with any previous dental treatment?

☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic examination or treatment?

☐ yes ☐ no ☐ dk/u Been under another dentist's care?

Specialist: _____

Other: _____

How often does the patient brush? _____

How often does the patient floss? _____

What is your primary concern? Why are you here? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date: _____
(Parent or Guardian or Responsible Party)

Signed: _____ Date: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

____

____

Signed: ______________________________ Date: ______________
(Parent or Guardian)

Signed: ______________________________ Date: ______________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

____

____

Signed: ______________________________ Date: ______________
(Parent or Guardian)

Signed: ______________________________ Date: ______________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

____

____

Signed: ______________________________ Date: ______________
(Parent or Guardian)

Signed: ______________________________ Date: ______________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

____

____

Signed: ______________________________ Date: ______________
(Parent or Guardian)

Signed: ______________________________ Date: ______________
(Dental Staff Member)