Omerza Orthodontics

Lorain 1740 Cooper Foster Park Rd W, Lorain, OH 44053 · (440) 960-2970

Medical & dental history

Answer for the patient · Today's date _____

Patient's name | Date of birth | Filled in by (if not the patient)

MEDICAL

Physician or pediatrician | Physician's phone | Last physical (month/year) | In good health? ☐ Yes ☐ No

Now under a doctor's care for | Hospital stays or operations (what, when)

Has the patient ever had, or do they now have:

Heart condition or murmur	☐ Y ☐ N	Artificial heart valve or joint	☐ Y ☐ N	Rheumatic fever	☐ Y ☐ N
High or low blood pressure	☐ Y ☐ N	Bleeding problem, bruises easily	☐ Y ☐ N	Anemia or blood disorder	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Thyroid condition	☐ Y ☐ N	Asthma or breathing trouble	☐ Y ☐ N
Seizures or epilepsy	☐ Y ☐ N	Fainting or dizzy spells	☐ Y ☐ N	Hepatitis or liver disease	☐ Y ☐ N
Kidney disease	☐ Y ☐ N	HIV or a weakened immune system	☐ Y ☐ N	Cancer, chemotherapy or radiation	☐ Y ☐ N
Osteoporosis or bone medicines	☐ Y ☐ N	Arthritis or joint problems	☐ Y ☐ N	Stomach trouble or eating disorder	☐ Y ☐ N
ADHD, autism, learning differences	☐ Y ☐ N	Anxiety about dental visits	☐ Y ☐ N	Hearing or vision difficulty	☐ Y ☐ N
Sinus trouble or hay fever	☐ Y ☐ N	Tonsils or adenoids removed	☐ Y ☐ N	Tobacco, vaping or nicotine use	☐ Y ☐ N
Pregnant or nursing (adults)	☐ Y ☐ N	Other condition (list below)	☐ Y ☐ N		

Allergies or reactions to:

Latex	☐ Y ☐ N	Nickel or other metals	☐ Y ☐ N	Penicillin or other antibiotics	☐ Y ☐ N
Local anesthetic (numbing)	☐ Y ☐ N	Aspirin, ibuprofen, codeine	☐ Y ☐ N	Foods (which?)	☐ Y ☐ N

Details of any "yes" above | Needs an antibiotic before dental work? ☐ Yes ☐ No ☐ Not sure

Medications, vitamins and supplements taken regularly (including inhalers and birth control):

Name	Dose, how often	Taken for

DENTAL

Last dental visit | Last dental X-rays | Brushes: ☐ 1× ☐ 2× a day | Flosses: ☐ Yes ☐ Sometimes ☐ No

Previous orthodontic treatment? ☐ Yes ☐ No | If yes: when, where, for how long | Wears a retainer now? ☐ Yes ☐ No

Thumb or finger sucking (ever)	☐ Y ☐ N	Nail biting, pen chewing	☐ Y ☐ N	Breathes through the mouth	☐ Y ☐ N
Snoring or restless sleep	☐ Y ☐ N	Clenching or grinding	☐ Y ☐ N	Jaw joint clicks or pops	☐ Y ☐ N
Jaw pain, locking, tiredness	☐ Y ☐ N	Frequent headaches	☐ Y ☐ N	Injury to teeth, jaws or face	☐ Y ☐ N
Missing or extra teeth	☐ Y ☐ N	Teeth sensitive to hot or cold	☐ Y ☐ N	Gums bleed when brushing	☐ Y ☐ N
Trouble chewing or biting	☐ Y ☐ N	Speech difficulty	☐ Y ☐ N	Plays contact sports	☐ Y ☐ N
Plays a wind instrument	☐ Y ☐ N	Self-conscious about the smile	☐ Y ☐ N	Family history of jaw or bite problems	☐ Y ☐ N

WHAT BRINGS YOU IN

What would you like us to look at? Who noticed it: the patient, a parent, the dentist?

Interested in: ☐ Metal braces ☐ Clear braces ☐ Clear aligners (Invisalign) ☐ No preference yet | Timing: ☐ As soon as it makes sense ☐ Just checking for now

The answers above are accurate to the best of my knowledge. I will tell the office if the patient's health or medications change during treatment.

Signature of patient, or parent or guardian if the patient is under 18 | Date

Office use Reviewed by _____ Date _____ Alerts: _____