BERNARDO CALDAS
ORTHODONTICS

# MEDICAL HISTORY

## PATIENT INFORMATION

Patient name

Date of birth

## MEDICAL INFORMATION

Please select Yes or No for each question and provide details where requested.

1. Is your child/patient currently under the care of a physician? ☐ Yes ☐ No
If yes, please explain:

2. Has your child/patient ever been hospitalized or had surgery? ☐ Yes ☐ No
If yes, please explain:

3. Is your child/patient currently taking any medications (prescription, over-the-counter, vitamins or supplements)? ☐ Yes ☐ No
If yes, please list:

4. Does your child/patient have any allergies (medications, foods, latex, etc.)? ☐ Yes ☐ No
If yes, please list and describe the reaction:

5. Does your child/patient have any medical conditions or developmental concerns? ☐ Yes ☐ No
If yes, please list:

## AIRWAY / SLEEP QUESTIONS

*Obstructive sleep apnea screening: please answer these questions to help us assess for possible sleep-disordered breathing.*

1. Does your child/patient snore? ☐ Yes ☐ No
2. Does your child/patient ever stop breathing during sleep (pauses in breathing)? ☐ Yes ☐ No
3. Does your child/patient breathe through the mouth during the day or night? ☐ Yes ☐ No
4. Does your child/patient often feel tired during the day or have trouble staying awake? ☐ Yes ☐ No
5. Does your child/patient have difficulty sleeping or wake up frequently at night? ☐ Yes ☐ No
6. Has your child/patient been diagnosed with sleep apnea or had a sleep study? ☐ Yes ☐ No
7. Does your child/patient have nasal congestion or frequent nasal allergies? ☐ Yes ☐ No
8. Does your child/patient have enlarged tonsils or adenoids? ☐ Yes ☐ No

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Date of birth

## JAW JOINTS, MUSCLES & DENTAL CONCERNS

Please answer for the patient. TMJ means the jaw joint; TMD refers to jaw-joint and jaw-muscle disorders. Select one response for each question.

| | Yes | No | Not sure |
|---|---|---|---|
| 1. Do you grind or clench your teeth? | ☐ | ☐ | ☐ |
| 2. Do your jaw joints click, pop or lock? | ☐ | ☐ | ☐ |
| 3. Do you have soreness in your jaw or face muscles? | ☐ | ☐ | ☐ |
| 4. Do you have ringing in your ears? | ☐ | ☐ | ☐ |
| 5. Do you have difficulty chewing or opening your jaw? | ☐ | ☐ | ☐ |
| 6. Have you ever been treated for TMJ or TMD problems? | ☐ | ☐ | ☐ |

For any Yes or Not sure: describe symptoms, when they began, frequency and affected side

If treated for TMJ/TMD: provider, approximate dates, treatment or nightguard / splint used

## OTHER INFORMATION

Other health information or concerns you would like us to know

## AUTHORIZATION

I certify that the information provided on both pages is true and complete to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's/patient's medical status.

By typing my full name below, I intend it to serve as my signature.

Signature of patient or parent / guardian (type full name)

Date