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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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?	☐	☐	☐
7. Do you have any broken or missing teeth?	☐	☐	☐

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

Broken or missing teeth: location and details, if known

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