School of Orthodontics
BROOKS REHABILITATION
COLLEGE OF HEALTHCARE SCIENCES

PATIENT HISTORY AND CLINICAL EXAMINATION FORM

Name: _____ **Patient ID:** _____
D.O.B.: _____ **Exam Date:** _____

HISTORY

Patient/Parent's Chief Concern: _____
Reason referred and by whom: _____
Is pt. presently under a Physicians care? [ ]Yes [ ]No
If YES: Details: _____
_____
Is pt. presently taking medications? [ ]Yes [ ]No
If YES: Details: _____
_____
Does pt. have any allergies to metals, plastics, etc. or medications? [ ]Yes [ ]No
If YES: Details: _____
_____
Is pt. presently under a Dentist's care? [ ]Yes [ ]No
If YES: Details: _____
_____
If NO: Date of last dental exam and findings:
_____
History of prior orthodontic treatment? [ ]Yes [ ]No
If yes, how long ago? _____
History of trauma to face, mouth or teeth? [ ]Yes [ ]No
If yes: Details: _____
Family History of jaw or teeth problems? [ ]Yes [ ]No
If yes: Details: _____

Disease/Disorder	Y	N
Blood/Bleeding Problem		
Breathing/Resp. Problem		
Cardiopathies, e.g.: Rheumatic Fever, Murmur		
Diabetes		
Endocrine Disorders		
Epilepsy/Seizure Disorders		
Fainting/Dizziness		
Gastrointestinal Problems		
Headaches/Neckaches		
Hepatitis/Liver Disease		
HIV/Infectious Disease		
Immune system: Suppressed/Compromised		
Joint Replacements		
Kidney Problems		
Learning Disorders		
Mitral Valve Prolapse		
Obstructive Sleep Apnea or Snoring		
Osteoporosis		
Pregnant/On Birth Control		
Rheumatologies/Arth./JRA		
Speech/Hearing Disorders		
SoreThroats/Chron. Strep		
Tonsillectomy/ Turbinectomy Adenoidectomy		

PSYCHOSOCIAL AND PHYSICAL GROWTH STATUS

Does pt. recognize a need for ortho tx? [ ]Yes [ ]No
Is pt. learning or physically disabled? [ ]Yes [ ]No
If YES: Details: _____
Does pt. have an emotional problem? [ ]Yes [ ]No
Does pt. have any oral habits? [ ]Yes [ ]No
If YES: Details:_____
If female, has menstruation started? [ ]Yes [ ]No
Has pt. experienced onset of puberty? [ ]Yes [ ]No
Has puberal growth spurt ceased? [ ]Yes [ ]No
Is continued growth expected? [ ]Yes [ ]No

NOTES

_____
_____
_____
_____
_____
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_____
Patient, parent, or legal guardian signature Date