13841 Hull Street Road, Suite 4
Midlothian, VA 23112
804.739.0963 | 804.745.0100

Pediatric Dentistry and
Orthodontics of Virginia
www.pdova.com

651 Southpark Boulevard
Colonial Heights, VA 23834
804.526.9815

Patient's Name: _____ DOB: _____

The answers are for office records only and will be considered confidential.
A thorough and complete history is vital to a proper orthodontic evaluation.
For the following questions mark, yes (Y), no (N), or don't know/understand (?).

Medical History

Now or in the past, has the patient had:

❑Y ❑N ❑? Birth defects or hereditary problems?
❑Y ❑N ❑? Bone fractures, any major accidents?
❑Y ❑N ❑? Rheumatoid or arthritic problems?
❑Y ❑N ❑? Endocrine or thyroid problems?
❑Y ❑N ❑? Kidney problems?
❑Y ❑N ❑? Diabetes?
❑Y ❑N ❑? Cancer, tumor, radiation treatment or chemotherapy?
❑Y ❑N ❑? Stomach ulcer or hyperacidity?
❑Y ❑N ❑? Polio, mononucleosis, tuberculosis or pneumonia?
❑Y ❑N ❑? Problems of the immune system?
❑Y ❑N ❑? AIDS or HIV positive?
❑Y ❑N ❑? Hepatitis, jaundice or liver problems?
❑Y ❑N ❑? Fainting spells, seizures, epilepsy or neurological problems?
❑Y ❑N ❑? Mental illness or behavioral problems?
❑Y ❑N ❑? Vision hearing, tasting or speech difficulties?
❑Y ❑N ❑? Loss of weight recently, poor appetite?
❑Y ❑N ❑? History of eating disorder (anorexia, bulimia)?
❑Y ❑N ❑? Excessive bleeding or bruising tendency, anemia or bleeding disorder?
❑Y ❑N ❑? High or low blood pressure?
❑Y ❑N ❑? Tires easily?
❑Y ❑N ❑? Chest pain, shortness of breath or swelling ankles?
❑Y ❑N ❑? Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart, defects, heart murmur or rheumatic heart disease)?
❑Y ❑N ❑? Skin disorder?
❑Y ❑N ❑? Do you eat a well-balanced diet?
❑Y ❑N ❑? Frequent headaches, colds or sore throat?
❑Y ❑N ❑? Eye, ear, nose or throat condition?
❑Y ❑N ❑? Hayfever, asthma, sinus trouble or hives?
❑Y ❑N ❑? Tonsil or adenoid conditions?
❑Y ❑N ❑? Osteoporosis

Allergies or reactions to any of the following:

❑Y ❑N ❑? Local anesthetics (Novocaine or Lidocaine)
❑Y ❑N ❑? Aspirin
❑Y ❑N ❑? Ibuprofen (Motrin, Advil)
❑Y ❑N ❑? Penicillin or other antibiotics
❑Y ❑N ❑? Sulfa drugs
❑Y ❑N ❑? Codeine or other narcotics
❑Y ❑N ❑? Metals (jewelry. clothing, snaps)
❑Y ❑N ❑? Latex (gloves, balloons)
❑Y ❑N ❑? Vinyl
❑Y ❑N ❑? Acrylic
❑Y ❑N ❑? Animals
❑Y ❑N ❑? Foods (specify)_____
❑Y ❑N ❑? Other substances, (specify)_____
❑Y ❑N ❑? Is the patient taking medications, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication_____ Taken for:_____
Medication_____ Taken for:_____
Medication_____ Taken for:_____

❑Y ❑N ❑? Do you currently have or ever had a substance abuse problem?
❑Y ❑N ❑? Do you chew or smoke tobacco
❑Y ❑N ❑? Operations?
Describe:_____
❑Y ❑N ❑? Hospitalized?
Describe:_____
❑Y ❑N ❑? Other physical problems or symptoms?
Describe:_____
❑Y ❑N ❑? Being treated by another health care professional?
Describe:_____
For:_____
Date of most recent physical exam?_____
Are there any other medical conditions that we should be aware of?
_____
_____

Meera Gokli, DDS
Pediatric Dentist
Diplomate American
Academy of Pediatric Dentistry

Steven Lubbe, DMD
Pediatric Dentist

David Keeton, DMD
Pediatric Dentist
Diplomate American
Academy of Pediatric Dentistry

April Bridges-Poquis, DDS
Orthodontist

Chad Schanilec, DDS
Orthodontist

Women Only

❑Y ❑N ❑? Has the patient started her monthly periods? If so, approximately when?
❑Y ❑N ❑? Is the patient pregnant?

Dental History

Now or in the past, has the patient had:

❑Y ❑N ❑? Primary (baby) teeth removed that weren't loose?
❑Y ❑N ❑? Permanent or supernumerary teeth removed?
❑Y ❑N ❑? Supernumerary or congenitally missing teeth?
❑Y ❑N ❑? Chipped or injured primary or permanent teeth?
❑Y ❑N ❑? Teeth sensitive to hot or cold; throb or ache?
❑Y ❑N ❑? Jaw fractures, cysts or mouth infections?
❑Y ❑N ❑? "Dead teeth" or root canals treated?
❑Y ❑N ❑? Bleeding gums, bad taste or mouth odor?
❑Y ❑N ❑? Periodontal "gum problems"?
❑Y ❑N ❑? Food impaction between teeth?
❑Y ❑N ❑? Frequent canker of cold sores
❑Y ❑N ❑? Thumb, finger, or sucking habit?
Until what age?_____
❑Y ❑N ❑? Abnormal swallowing habit (tongue thrusting)?
❑Y ❑N ❑? History of speech problems?
❑Y ❑N ❑? Mouth breathing habit, snoring, or difficulty breathing?
❑Y ❑N ❑? Tooth grinding, jaw clenching, clicking or locking?
❑Y ❑N ❑? Any pain in jaw or ringing in the ears
❑Y ❑N ❑? Pain or soreness in the face or around the ears?
❑Y ❑N ❑? Difficulty in chewing or jaw opening?
❑Y ❑N ❑? Have you ever been treated for "TMD" or "TMJ" problems?
❑Y ❑N ❑? Loose, broken or missing restorations (fillings)?
❑Y ❑N ❑? Any teeth irritating cheek, lip, tongue or palate?
❑Y ❑N ❑? Concerned about spaced, crooked or protruding teeth?
❑Y ❑N ❑? Aware or concerned about under or over developed jaw?
❑Y ❑N ❑? Any relative with similar tooth or jaw relationships?
❑Y ❑N ❑? Any wisdom tooth problems?
❑Y ❑N ❑? Had periodontal (gum) treatment?
❑Y ❑N ❑? Serious trouble associated with any previous dental treatment?
❑Y ❑N ❑? Would patient object to wearing orthodontic appliances (braces) should they be indicated?
❑Y ❑N ❑? Prior orthodontic examination or treatment?
❑Y ❑N ❑? Been under another dentist's care?
Specialist: _____
Other:_____

Family Medical History

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

Bleeding disorders: _____ Severe allergies::_____
Diabetes: :_____ Unusual dental problems::_____
Arthritis: :_____ Jaw size imbalance:_____
Metabolic disturbances:_____
Any other family medical conditions that we should know about?_____
How often does your child brush teeth? _____ Floss?_____
What is your primary concern?_____

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

Signed (Parent or Guardian):_____Print_____

Date Signed::_____