Dr. Iain Meldrum BSc, DDS, MSc, FRCD(C)
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(905) 877-0145

273 Broadway Ave Suite 201
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(519) 941-8210

Orthodontics and Temporomandibular Joint Disorders
Patient's Clinical History/Family Information

Patients Name: ________________________________ Age: _____ Sex: _______ D.O.B: __________________________

Address: ____ City: _____________________Postal Code: _________

____

Best # during business hours: ___________________________ Best Email: _____________________________________

School: ____________________________ Grade: _______

Parent	Parent
Name: ____	Name: ____
D.O.B: ____	D.O.B: ____
Marital Status: ◯Single ◯Married ◯Separated ◯Divorced ◯Widowed ◯Remarried	Marital Status: ◯Single ◯Married ◯Separated ◯Divorced ◯Widowed ◯Remarried
Home address: __________________________________	Home address: __________________________________
Best #: ____	Best #: ____
Employed by: ___________________________________	Employed by: ___________________________________
Work Address: __________________________________	Work Address: __________________________________
Work #: ____	Work #: ____
Does Mother have Orthodontic Insurance? ◯Yes ◯No	Does Father have Orthodontic Insurance? ◯Yes ◯No
Ins Company Name: _______________________________	Ins Company Name: _______________________________

Patients Family Dentist: _______________________________ Phone number: __________________________________

Patients Family Physician: _____________________________ Phone number: __________________________________

Whom may we thank for referring you to our office: ____

If responsible party is other than the patient's parents, please give information: ◯ Not Applicable

Name: ____ Relationship to parent: _____________________________

Address: ____ Tel #: ______________________________

Does responsible party have Orthodontic Insurance ◯ YES ◯ NO If so, Name of Ins Company: ___________________

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Medical History

Has patient had or does patient have any of the following?

Condition		Condition	
Rheumatic Fever	◯Yes ◯No	Persistent Headaches	◯Yes ◯No
Heart Murmur	◯Yes ◯No	Neck Pains	◯Yes ◯No
High Blood Pressure	◯Yes ◯No	Nerve or Brain Disease	◯Yes ◯No
Heart attack / Stroke	◯Yes ◯No	Migraine	◯Yes ◯No
Blood Vessel Disease	◯Yes ◯No	Epilepsy	◯Yes ◯No
Blood Disorder	◯Yes ◯No	Mental Health Problems	◯Yes ◯No
AIDS/HIV Infection	◯Yes ◯No	Bone Disorders	◯Yes ◯No
Diabetes	◯Yes ◯No	Arthritis (Any Type)	◯Yes ◯No
Ulcers	◯Yes ◯No	Sleep Apnea	◯Yes ◯No
Herpes (Any Type)	◯Yes ◯No	Ear Disorder	◯Yes ◯No
Psoriasis	◯Yes ◯No	Sinus Infection	◯Yes ◯No
Cancer	◯Yes ◯No	Swollen Glands	◯Yes ◯No
Hepatitis	◯Yes ◯No	Allergies	◯Yes ◯No

Comments: ____

Please list any other significant information about the patients' medical history: ____________________
____

◯Yes ◯No Is patient under a physician's care at present? If yes, reason: ____________________

◯Yes ◯No Is patient presently or has ever been under the care of Psychiatrist or Psychologist?
If yes, describe ____

◯Yes ◯No Is patient currently taking any medication? If yes, describe ____________________

◯Yes ◯No Is patient allergic to any medications? (EG: aspirin, penicillin, etc.) If yes, what? ____________

◯Yes ◯No Has patient ever had general anesthesia? If yes, when? ____________________

Dental History

◯Yes ◯No Do any of your teeth hurt? If yes where ______________________________

◯Yes ◯No Have any wisdom teeth been removed? How many? ____________________

◯Yes ◯No Have you ever had treatment for a periodontal (gum) disease? If yes Describe: ____________
____

◯Yes ◯No Have you ever had previous orthodontic treatment (braces)? If yes, when? ____________
Orthodontist name: ____________ Address: ______________________

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◯Yes ◯No Have there been any injuries to your mouth/teeth? If yes, describe ______________________________

◯Yes ◯No Have you ever had a head/neck injury? If yes, describe ____

◯Yes ◯No Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe __________
____
____

◯Yes ◯No Have you ever had any surgery in the head/neck area? If yes, describe ______________________________

◯Yes ◯No Do you clench or grind your teeth? If yes, ◯ while sleeping ◯ under stress ◯ Other: ________________

◯Yes ◯No Do your jaw muscles ever feel tired? If yes, when? ____

◯Yes ◯No Do you ever notice soreness, tightness or pain in the muscles around the jaws and face? If yes, describe
____

◯Yes ◯No Does it hurt to chew? If yes, where does it hurt? ____

◯Yes ◯No Do you hear clicking/popping or grating sounds in your jaw joints? If yes, describe ___________________
____

Did these joint sounds begin gradually or suddenly? ____

◯Yes ◯No Was there some specific event that started the joint sounds? If yes, describe ________________________
____

◯Yes ◯No Have you ever experienced difficulty in opening or closing your jaws? If yes, describe___________________
____

◯Yes ◯No Have your jaws ever locked closed?

◯Yes ◯No Have your jaws ever locked wide open?

◯Yes ◯No Do you feel pain in your jaw joints? If yes, describe ____
____

Do you have any of the following habits?

◯Yes ◯No Finger/Thumb sucking

◯Yes ◯No Lip biting

◯Yes ◯No Nail biting

◯Yes ◯No Gum chewing

◯Yes ◯No Ice chewing

Growth and Development

Patients current height? ____

◯Yes ◯No Has patient reached adolescent growth? ____

◯Yes ◯No GIRLS- Has monthly cycle started yet? If so, when? ____

◯Yes ◯No BOYS- Has voice changed yet? If so, when? ____

◯Yes ◯No Are there any learning disabilities? If yes, explain ____

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◯Yes ◯No Are there other children in the family? Names and ages ____

____

◯Yes ◯No Has any other member of the family had orthodontic treatment? Where? ____________________________

Please describe why you sought out this consultation ____

____

____

◯Yes ◯No Has patient ever been treated for this problem before? If yes, please describe the diagnosis and

Treatment. ____

____

____

Any information you can give me concerning your child will be appreciated. The more we know about each patient the more help we can give in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies.

____

____

____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

____ ____

(Signature of Responsible Adult) Date

Doctor's Notes

____

____ ____

(Signature of Doctor) Date

Patient Coordinator Checklist and Notes

Contacts with other doctors 1. 2. 3.

Special notes ____

____

Additional doctor's notes ____

____