Dr. Iain Meldrum BSc, DDS, MSc, FRCD(C)
Dr. Chelsea Ko-Adams HBSc, DDS, MSc, FRCD(C)
Dr. Gabriella Kaminer Levin BA(Hons), DDS, MS, Cert (Ortho)

116 Guelph St
Georgetown, ON L7G 4A3
(905) 877-0145

273 Broadway Ave Suite 201
Orangeville, ON L9W 1K3
(519) 941-8210

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

Patients Name: _____Sex: _____ D.O.B: _____

Address: _____ City: _____Postal Code: _____

_____

Best # during business hours: _____ Best Email: _____

Patients Family Dentist: _____ Phone number: _____

Patients Family Physician: _____ Phone number: _____

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

Medical History

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

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 your medical history: _____
_____

◯Yes ◯No Are you under a physician's care at present? If yes, reason: _____

◯Yes ◯No Are you presently or have ever been under the care of Psychiatrist or Psychologist?
If yes, describe _____

◯Yes ◯No Are you currently taking any medication? If yes, describe _____

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◯Yes ◯No Are you allergic to any medications? (EG: aspirin, penicillin, etc.) If yes, what? _____

◯Yes ◯No Have you 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: _____

◯Yes ◯No Have there been any injures 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?

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

Please describe why you sought out this consultation _____
_____
_____

◯Yes ◯No Have you ever been treated for this problem before? If yes, please describe the diagnosis and treatment. _____
_____
_____

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 Patient) Date

Doctor's Notes
_____
_____
_____
_____
_____

_____ _____

(Signature of Doctor) Date