RIX ORTHODONTICS
natural healthy smiles

Patient information and medical history

Please complete this form with your information and history.
Please check **only** those that apply.

Name: _____ ◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Dr

Date of Birth: _____ Age: _____ Gender: ◯ Male ◯ Female

Address: _____ City: _____ Postal Code: _____

Phone #: cell _____ home _____

Email: _____

Family dentist: _____ Referred by: _____

Physician: _____

Name(s) of other family members being treated at our office: _____

MEDICAL HISTORY:
Check any of the following health concerns, past or present

□ ADD/ADHD	□ Asthma	□ Diabetes	□ Liver Disease
□ AIDS/HIV	□ Bleeding Disorder	□ Heart condition/stroke	□ Mitral valve relapse
□ Anxiety Disorder	□ Cancer Treatment	□ Hepatitis/Jaundice	□ Rheumatic Fever
□ Arthritis	□ Depression	□ Kidney Disease	□ Seizures/Epilepsy
□ Thyroid	□ Tuberculosis	□ Other_____	

☐ I am in good health.
☐ I am under a physician's care. Please explain: _____
☐ I am on medications. Please specify: _____
_____
☐ I have been required to take antibiotics prior to receiving dental treatment.
Please specify: _____

I have or have had:
☐ frequent respiratory infections.
☐ frequent ear infections.

☐ tubes in the ears.
☐ enlarged tonsils or adenoids.
☐ tonsils or adenoids removed. If so, when? _____
☐ allergies. Please specify: _____
☐ digestive problems. Please specify: _____

DENTAL HISTORY:

□ Jaw Discomfort □ Tooth Grinding □ Jaw Clicking
□ Tooth Clenching □ Jaw Locking □ Frequent Headaches

☐ I have had injuries/trauma to the face, mouth, or teeth.
Please specify: _____
☐ I am missing or have extra primary (baby) and/or permanent (adult) teeth?
Please specify: _____
☐ I have had primary (baby) and/or permanent (adult) teeth extracted by a dentist.
Please specify: _____

PREGNANCY/BIRTH HISTORY:

My birth was:
□ Premature □ Full term □ C-Section

Please specify any complications with the pregnancy or your birth:
_____
_____
_____

DEVELOPMENT:

☐ I was breast fed. For how long? _____
Please specify any difficulties with breast feeding: _____
☐ I was bottle fed. For how long? _____
☐ I used a pacifier/soother. For how long? _____
☐ I used a sippy cup.
At what age did you start eating soft food? _____ hard food? _____
☐ I am a slow eater.
☐ I am a fast eater.
☐ I am a noisy eater.
☐ I chew with an open mouth.

☐ I tear food into tiny pieces.
☐ I need to drink constantly when eating solid food.
☐ I have difficulty with certain food textures. Please specify: _____
☐ I eat one food at a time.
☐ I do not let different foods touch each other.
☐ I have trouble licking ice cream cones.
☐ I have trouble swallowing in general. Please specify: _____
☐ I have trouble swallowing pills. Please specify: _____
☐ I have jaw joint or facial pain when eating certain foods.
Please specify: _____

BREATHING:

☐ I have trouble breathing through the nose.
☐ I have been assessed by an ENT specialist.
Please specify: _____
☐ I have a pet cat and/or dog.
☐ I breathe through my mouth during the day.
☐ I breathe through my mouth during the night.
☐ I drool while sleeping.
☐ My nose is often "stuffy".
☐ My mouth is often open when watching TV, reading, or using electronic devices.
☐ My lips are usually closed.
☐ My lips are usually apart.
☐ My lips are usually dry or chapped.
☐ I chronically lick my lips.

SPEECH:

☐ I have problems with speech or creating certain sounds.
Please specify: _____
☐ I have had speech therapy.
Please specify: _____

HABITS:

☐ I sucked my thumb or finger(s). Until what age?_____
☐ I sucked on a blanket. Until what age?_____
☐ I bite/bit my nails. Until what age?_____
☐ I am/was a lip biter. Until what age?_____
☐ I am/was a lip sucker. Until what age? _____

☐ I am a gum chewer.
☐ I have a habit of chewing on pencils/pens.
☐ I have/had some other sucking/biting habit. Please specify: _____
☐ I play a musical instrument. Please specify: _____

SUPPLEMENTAL QUESTIONS:

What is/are the reason(s) for seeking orthodontic treatment?
Please specify: _____
☐ I have had previous orthodontic evaluations.
☐ I have had previous orthodontic treatment.
Please specify: _____
☐ Is there any dental work to be done at your family dentist?
Please specify: _____
When was your last dental checkup? _____

SIGNATURE: _____ **DATE:** _____

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ADULT SLEEP QUESTIONNAIRE

PATIENT NAME _____ DATE _____

Please complete this form as accurately as you can. Orthodontic treatment can have a significant effect on sleep and breathing disorders which can subsequently have a significant effect on your overall health. We will work with you to manage any sleep and/or breathing disorders present.

Please check all of the following items that apply to you:

- ☑ I occasionally snore.
- ☐ I frequently snore.
- ☑ I have been told that I sometimes stop breathing during sleep.
- ☑ I have trouble falling asleep.
- ☑ I wake up frequently during sleep.
- ☑ I frequently breathe through my mouth during sleep.
- ☑ I frequently breathe through my mouth during the day.
- ☑ I grind my teeth during sleep.
- ☑ I experience excess daytime sleepiness.
- ☑ I sometimes fall asleep while driving.
- ☐ I frequently fall asleep while a passenger in a car.
- ☑ I frequently awake with a headache.
- ☑ I frequently awake unrefreshed.
- ☑ I frequently awake with a dry mouth.
- ☑ I frequently awake with nasal congestion.
- ☑ I frequently awake with chest pain.
- ☑ I frequently awake choking or gasping.
- ☑ I frequently awake with excessive sweating.
- ☑ I have recently gained weight.
- ☑ I have recently experienced increased irritability.
- ☑ I have recently experienced depression.
- ☑ I have recently experienced a deteriorating memory.
- ☑ I have high blood pressure.
- ☑ I am a smoker.
- ☑ I drink alcohol.

I routinely get ___ hours sleep per night.

PATIENT'S SIGNATURE: _____