



Medical Dental History Form For Adult Patient

PATIENT

Date _____
 Patient's Last name _____ First name _____ Middle initial _____
 Birth date _____ Sex: Male Female I prefer to be called _____
 Marital Status: Single Married Separated Divorced Widowed
 Home address _____ City, State, Zip code _____
 Home phone _____ Cell phone _____
 E-mail address _____
 Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relative's name _____
 Address (if different than patient address) _____
 Home phone _____ Cell phone _____ Work phone _____

DENTIST

Patient's Dentist _____ Address, City, State _____
 Last seen _____ Reason _____ Next appointment _____
 Other dentists/dental specialists now being seen: Name _____ City, State _____
 Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____
 Who suggested that you might need orthodontic treatment? _____
 Why did you select our office? _____
 Have you had any previous orthodontic treatment? Please describe _____
 Have any other family members been treated in this office? Please name them. _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____
 Social Security # - - _____ Relationship to patient _____
 Address and phone (if not listed above) _____
 Employer _____ Insurance company _____
 Group # _____ ID # _____

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements or non-prescription medicines, including fluoride supplements that you take.

 Have you ever taken any medications to strengthen your bones? Please describe. _____
 Do you take antibiotic pre-medication before any dental procedures? Yes No
 Do you or have you ever had a substance abuse problem? _____
 Do you chew or smoke tobacco? _____
 Any other physical problems? _____
 How often do you brush? _____
 How often do you floss? _____
 Women: Are you pregnant? Yes No Are you trying to become pregnant? Yes No

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions mark yes or no.

MEDICAL HISTORY

Now or in the past, have you had:

- YES NO Birth defects or hereditary problems?
- YES NO Bone fractures, or major injuries?
- YES NO Any injuries to face, head, neck?
- YES NO Arthritis or joint problems?
- YES NO Endocrine or thyroid problems?
- YES NO Diabetes or low sugar?
- YES NO Kidney problems?
- YES NO Cancer, tumor, radiation or chemotherapy?
- YES NO Stomach ulcer, hyperacidity, acid reflux?
- YES NO Immune system problems?
- YES NO History of osteoporosis?
- YES NO Gonorrhea, syphilis, herpes?
- YES NO AIDS or HIV positive?
- YES NO Hepatitis, jaundice or other liver problem?
- YES NO Polio, mononucleosis, tuberculosis, pneumonia?
- YES NO Seizures, fainting spells, neurologic problem?
- YES NO Mental health disturbance or depression?
- YES NO Vision, hearing, or speech problems?
- YES NO History of anorexia, bulimia?
- YES NO High or low blood pressure?
- YES NO Excessive bleeding or bruising, anemia?
- YES NO Frequent headaches or migraines?
- YES NO Do you eat a well-balanced diet?
- YES NO Skin disorder
- YES NO Tonsil or adenoid condition?
- YES NO Heart defects, heart murmur, rheumatic heart disease?
- YES NO Chest pain, shortness of breath, tire easily, swollen ankles?
- YES NO Frequent ear infections, colds, throat infections?
- YES NO Tonsil or adenoid condition? Angina, arteriosclerosis, stroke or heart attack?
- YES NO Do you frequently breathe through your mouth?

Please list any known allergies: _____

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature: _____ **Date:** _____

Dentist Signature: _____ **Date:** _____

DENTAL HISTORY

Now or in the past, have you had:

- YES NO Permanent or extra teeth removed?
- YES NO Supernumerary or congenitally missing teeth?
- YES NO Chipped or injured primary or permanent teeth?
- YES NO Any sensitive or sore teeth?
- YES NO Bleeding gums, bad taste or mouth odor?
- YES NO Jaw fractures, cysts, infections?
- YES NO Any teeth treated with root canals or pulpotomies?
- YES NO "Gum boils," frequent canker sores or cold sores?
- YES NO History of speech problems or speech therapy?
- YES NO Difficulty breathing through nose?
- YES NO Food impaction between the teeth?
- YES NO Mouth breathing habit or snoring at night?
- YES NO History of speech problems?
- YES NO Frequent oral habits
- YES NO Teeth causing irritation to lip, cheek or gums?
- YES NO Abnormal swallowing (tongue thrust)?
- YES NO Tooth grinding or clenching?
- YES NO Clicking, locking in jaw joints?
- YES NO Soreness in jaw muscles or face muscles?
- YES NO Ringing in ears, difficulty in chewing or opening jaw?
- YES NO Have you ever been treated for "TMJ" or "TMD"?
- YES NO Any broken or missing fillings?
- YES NO Have you ever been diagnosed with gum disease?
- YES NO Have you ever had previous orthodontic treatment?