

DENTAL MEDICAL HISTORY FORM - **ADULT**

Patient's Name _____ Sex _____ Age _____
 DOB _____ SSN _____ E-Mail _____
 Home Phone _____ Work Number _____ Cell _____
 Address _____ City _____ Zip _____
 Employer _____ Occupation _____
 Other Family Members Treated _____
 Musical Instrument Played _____
 Sports/Hobbies _____
 Parent is (circle one) Single Married Widowed Separated Divorced
 Name of Spouse _____ Work Number _____
 Name of Dentist _____ Date of Last Check-Up _____
 Whom may we thank for referring you? _____
 Emergency Contact & Number _____ Relationship _____

Primary Insurance Company _____ Subscriber Name: _____
 SSN _____ DOB _____ Employer _____ Work Phone Number _____
 Work Address _____ City _____ Zip _____
 Secondary Insurance Company _____ Subscriber Name: _____
 SSN _____ DOB _____ Employer _____ Work Phone Number _____
 Work Address _____ City _____ Zip _____

For the following questions, circle **yes**, **no**, or **don't know/understand**. The answers are for office records only and will remain confidential. A thorough and complete history is vital for a proper orthodontic evaluation.

MEDICAL HISTORY

- | | |
|---|---|
| Yes No DK/U Birth defects or hereditary problems? | Yes No DK/U AIDS or HIV positive? |
| Yes No DK/U Bone fractures, any major accidents? | Yes No DK/U Hepatitis, jaundice, or liver problems? |
| Yes No DK/U Rheumatoid or arthritic conditions? | Yes No DK/U Sexually transmitted diseases? |
| Yes No DK/U Endocrine or thyroid problems? | Yes No DK/U Fainting spells, seizures, epilepsy, or neurologic problems? |
| Yes No DK/U Kidney problems? | Yes No DK/U Mental health or behavioral problems? |
| Yes No DK/U Diabetes? | Yes No DK/U Vision, hearing, tasting, or speech difficulties? |
| Yes No DK/U Cancer or been treated for a tumor? | Yes No DK/U Loss of weight recently, poor appetite? |
| Yes No DK/U Stomach ulcer or hyperacidity? | Yes No DK/U Excessive bleeding, black & blue tendency, anemia, or bleeding disorder |
| Yes No DK/U Polio, mono, tuberculosis? | Yes No DK/U High or low blood pressure? |
| Yes No DK/U Problems of the immune system? | Yes No DK/U Easily tired? |
| Yes No DK/U High or low blood pressure? | |

Yes No DK/U Chest pain, shortness of breath, or swelling ankles?
 Yes No DK/U Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart disease or rheumatic heart?)
 Yes No DK/U Skin disorders?
 Yes No DK/U Do you have a normal and good diet?
 Yes No DK/U Frequent headaches, colds, or sore throats?
 Yes No DK/U Any history of speech problems?
 Yes No DK/U Eye, ear, nose, throat condition?
 Yes No DK/U Hayfever, asthma, sinus trouble, hives?
 Yes No DK/U Tonsil, or adenoid conditions?
 Yes No DK/U Allergies or drug reactions?
 Yes No DK/U Are you taking medication, nutrient supplements or non prescription medicine? Please name them.

 Yes No DK/U Does you currently have or ever had a substance abuse problem?
 Yes No DK/U Operations? _____
 Yes No DK/U Hospitalized for? _____
 Yes No DK/U Other physical problems or symptoms?
 Yes No DK/U Being treated by another health care professional? For _____
 Yes No DK/U Are you in good health? Date of most recent physical exam? _____

FEMALE PATIENT

Yes No DK/U Are you pregnant?
 Yes No DK/U Are you taking birth control pills?
 Yes No DK/U Are you anticipating becoming pregnant?

DENTAL HISTORY

Yes No DK/U Chipped or injured baby or permanent tooth?
 Yes No DK/U Teeth sensitive to hot or cold; teeth throb or ache?
 Yes No DK/U Jaw fractures, cysts, mouth infections?
 Yes No DK/U "Dead teeth", root canals treated?
 Yes No DK/U Bleeding gums, bad taste, mouth odor?
 Yes No DK/U Periodontal "gum problems"?
 Yes No DK/U Food impactions between teeth?
 Yes No DK/U "Gum boils", frequent canker sores?
 Yes No DK/U Thumb, finger, sucking habit? Until Age _____
 Yes No DK/U Abnormal swallowing habit (tongue thrusting)?
 Yes No DK/U Mouth breathing habit, snoring, difficulty in breathing?
 Yes No DK/U Tooth grinding, jaw clenching, clicking, locking?
 Yes No DK/U Any pain in jaw or ringing in the ears?
 Yes No DK/U Do you experience any pain or soreness in the Muscles of your face or around the ears? (Your jaw joint and facial muscle pain?)
 Yes No DK/U Difficulty encountered in chewing or jaw opening?
 Yes No DK/U Have you ever been treated for "TMJ" problems?

Yes No DK/U History of supernumerary or congenitally missing teeth?
 Yes No DK/U Have any permanent teeth been removed?
 Yes No DK/U Aware of loose, broken or missing restorations?
 Yes No DK/U Have you ever had orthodontic treatment or worn a "retainer" or "bite plate"?
 Yes No DK/U Have you recently been under another dentist's care? Specialist _____
 Yes No DK/U Have you ever had periodontal (gum) disease?
 Yes No DK/U Concerned about spaced, crooked, protruding teeth?
 Yes No DK/U Aware or concerned about under or over developed jaw?
 Yes No DK/U Any relative with similar tooth or jaw relationships?
 Yes No DK/U Any wisdom tooth problems?
 Yes No DK/U Have you had any serious trouble associated with any previous dental treatment?

What is your primary concern? – Why are you here?

Date of most recent examination _____

How often does patient brush _____ Floss _____

What is the patient's or parent's primary concern – Why are you here?

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointment, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

I have read and understand the above questions. I will not hold my Orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

If there are any changes later to this history record or dental/medical status I will so inform this practice

Signature of patient _____ Date _____

History Update or Changes: Date: Comments: Signature:

