CONFIDENTIAL DATE_____

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 (select 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_____

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

Yes	No	DK/U	
☐	☐	☐	Chest pain, shortness of breath, or swelling ankles?
☐	☐	☐	Cardiovascular problem (heart trouble, heart attack angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart disease or rheumatic heart?
☐	☐	☐	Skin disorders?
☐	☐	☐	Do you have a normal and good diet?
☐	☐	☐	Frequent headaches, colds, or sore throats?
☐	☐	☐	Any history of speech problems?
☐	☐	☐	Eye, ear, nose, throat condition?
☐	☐	☐	Hayfever, asthma, sinus trouble, hives?
☐	☐	☐	Tonsil, or adenoid conditions?
☐	☐	☐	Allergies or drug reactions?
☐	☐	☐	Are you taking medication, nutrient supplements or non prescription medicine? Please name them.
☐	☐	☐	Do you currently have or ever had a substance abuse problem?
☐	☐	☐	Operations?_____
☐	☐	☐	Hospitalized for?_____
☐	☐	☐	Other physical problems or symptoms?
☐	☐	☐	Being treated by another health care professional? For_____
☐	☐	☐	Are you in good health? Date of most recent physical exam?_____

FEMALE PATIENT

☐	☐	☐	Are you pregnant?
☐	☐	☐	Are you taking birth control pills?
☐	☐	☐	Are you anticipating becoming pregnant?

DENTAL HISTORY

☐	☐	☐	Chipped or injured baby or permanent tooth?
☐	☐	☐	Teeth sensitive to hot or cold; teeth throb or ache?
☐	☐	☐	Jaw fractures, cysts, mouth infections?
☐	☐	☐	"Dead teeth", root canals treated?
☐	☐	☐	Bleeding gums, bad taste, mouth odor?
☐	☐	☐	Periodontal "gum problems"?
☐	☐	☐	Food impactions between teeth?
☐	☐	☐	"Gum boils", frequent canker sores?
☐	☐	☐	Thumb, finger, sucking habit? Until Age_____
☐	☐	☐	Abnormal swallowing habit (tongue thrusting)?
☐	☐	☐	Mouth breathing habit, snoring, difficulty breathing?
☐	☐	☐	Tooth grinding, jaw clinching, clicking, locking?
☐	☐	☐	Any pain in jaw or ringing in the ears?
☐	☐	☐	Do you experience any pain or soreness in the Muscles of your face or around the ears? (Your jaw joint and facial muscle pain?)
☐	☐	☐	Difficulty encountered in chewing or jaw opening?
☐	☐	☐	Have you ever been treated for "TMJ" problems?

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

_____

_____

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