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____

Patient 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___________________

Dental 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 Bone fractures, any major accidents?

Yes No DK/U Rheumatoid or arthritic conditions?

Yes No DK/U Endocrine or thyroid problems?

Yes No DK/U Kidney problems?

Yes No DK/U Diabetes?

Yes No DK/U Cancer or been treated for a tumor?

Yes No DK/U Stomach ulcer or hyperacidity?

Yes No DK/U Polio, mono, tuberculosis?

Yes No DK/U Problems of the immune system?

Yes No DK/U High or low blood pressure?

Yes No DK/U AIDS or HIV positive?

Yes No DK/U Hepatitis, jaundice, or liver problems?

Yes No DK/U Sexually transmitted diseases?

Yes No DK/U Fainting spells, seizures, epilepsy, or neurological problems?

Yes No DK/U Mental health or behavioral problems?

Yes No DK/U Vision, hearing, tasting, or speech difficulties?

Yes No DK/U Loss of weight recently, poor appetite?

Yes No DK/U Excessive bleeding, black & blue tendency, anemia, or bleeding disorder

Yes No DK/U Easily tired?

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? Please name them.

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____

Yes No DK/U Known reactions to any drugs? Please name them.

____

____

Yes No DK/U Are you taking medication, nutrient supplements or non prescription medicine? Please name them.

____

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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 clinching, 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?

Date of most recent examination________________________________

How often does patient brush______________ Floss _______________

What is your 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

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Signature of patient Date

History Update or Changes: Date: Comments: Signature:

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