# MEDICAL DENTAL HISTORY FORM — ADULT

Date: _____

Title: Mrs. ☐ Ms. ☐ Miss. ☐ Mr. ☐ Dr. ☐

**CONFIDENTIAL**

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐ Preferred Name: _____

S.S.N./S.I.N.: _____ Home Phone No.: _____ Cell No.: _____

Patient's Address: _____ E-mail address: _____

City: _____ State/Province: _____ Zip Code: _____

Occupation: _____ Employer: _____

Business Phone No.: _____ Name of Spouse/Closest Relative: _____

Phone No. (if different from yours): _____ Relationship To You: _____

Address (if different from yours): _____

City: _____ State/Province: _____ Zip Code: _____

Name Of Patient's Dentist: _____ Date Last Seen: _____

Name Of Patient's Physician(s): _____ Date Last Seen: _____

Who suggested that you might need orthodontic treatment? _____ Referred by _____

Who Is Financially Responsible For This Account? _____

Address (if different than patient's): _____ Phone No.: _____

City: _____ State/Province: _____ Zip Code: _____

Insurance Coverage For Dental Treatment? Yes ☐ No ☐ Insurance Coverage For Orthodontic Treatment? Yes ☐ No ☐

Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employer: _____

Dental Insurance Company: _____ Group No.: _____

## MEDICAL HISTORY

**Now or in the past, have you had:**

☐ Yes ☐ No Birth defects or hereditary problems?
☐ Yes ☐ No Bone fractures, any major accidents?
☐ Yes ☐ No Rheumatoid or arthritic conditions?
☐ Yes ☐ No Endocrine or thyroid problems?
☐ Yes ☐ No Kidney problems?
☐ Yes ☐ No Diabetes?
☐ Yes ☐ No Cancer, tumor, radiation treatment or chemotherapy?
☐ Yes ☐ No Stomach ulcer or hyperacidity?
☐ Yes ☐ No Polio, mononucleosis, tuberculosis, pneumonia?
☐ Yes ☐ No Problems of the immune system?
☐ Yes ☐ No AIDS or HIV positive?
☐ Yes ☐ No Hepatitis, jaundice or liver problems?
☐ Yes ☐ No Fainting spells, seizures, epilepsy or neurological problems?
☐ Yes ☐ No Mental health disturbance or depression?
☐ Yes ☐ No Vision, hearing, tasting or speech difficulties?
☐ Yes ☐ No Loss of weight recently, poor appetite?
☐ Yes ☐ No History of eating disorders (anorexia, bulimia)?
☐ Yes ☐ No Excessive bleeding or bruising tendency, anemia or bleeding disorders?
☐ Yes ☐ No High or low blood pressure?
☐ Yes ☐ No Tires easily?
☐ Yes ☐ No Chest pain, shortness of breath or swollen ankles?
☐ Yes ☐ No Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐ Yes ☐ No Skin disorder?
☐ Yes ☐ No Do you have a well-balanced diet?
☐ Yes ☐ No Frequent headaches, colds or sore throats?
☐ Yes ☐ No Eye, ear, nose or throat condition?
☐ Yes ☐ No Hayfever, asthma, sinus trouble or hives?
☐ Yes ☐ No Tonsil or adenoid conditions?
☐ Yes ☐ No Osteoporosis?

**Allergies or reactions to any of the following:**

☐ Yes ☐ No Local anesthetics (Novocaine or Lidocaine)
☐ Yes ☐ No Aspirin
☐ Yes ☐ No Ibuprofen (Motrin, Advil)
☐ Yes ☐ No Penicillin or other antibiotics
☐ Yes ☐ No Sulfa drugs
☐ Yes ☐ No Codeine or other narcotics
☐ Yes ☐ No Metals (jewelry, clothing snaps)
☐ Yes ☐ No Latex (gloves, balloons)
☐ Yes ☐ No Vinyl
☐ Yes ☐ No Acrylic
☐ Yes ☐ No Animals
☐ Yes ☐ No Foods (specify) _____
☐ Yes ☐ No Other substances (specify) _____
☐ Yes ☐ No Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

☐ Yes ☐ No Do you currently have or ever had a substance abuse problem?
☐ Yes ☐ No Do you chew or smoke tobacco?
☐ Yes ☐ No Operations? Describe: _____

☐ Yes ☐ No Hospitalized? Describe: _____

☐ Yes ☐ No Other physical problems or symptoms? Describe: _____

☐ Yes ☐ No Being treated by another health care professional?
For: _____
Date of most recent physical exam? _____

Do you have any other medical conditions that we should know about?

## WOMEN ONLY

☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Are you anticipating pregnancy?

## FAMILY MEDICAL HISTORY

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

Bleeding disorders _____
Diabetes _____
Arthritis _____
Severe allergies _____
Unusual dental problems _____
Jaw size imbalances _____
Any other family medical conditions that we should know about?

How often do you brush: _____ Floss: _____
Date of last dental exam _____
What is your primary concern? Why are you here? _____

## DENTAL HISTORY

**Now or in the past, have you had:**

☐ Yes ☐ No Permanent or "extra" (supernumerary) teeth removed?
☐ Yes ☐ No Supernumerary (extra) or congenitally missing teeth?
☐ Yes ☐ No Chipped or otherwise injured primary (baby) or permanent teeth?
☐ Yes ☐ No Teeth sensitive to hot or cold; teeth throb or ache?
☐ Yes ☐ No Jaw fractures, cysts or mouth infections?
☐ Yes ☐ No "Dead teeth" or root canals treated?
☐ Yes ☐ No Bleeding gums, bad taste or mouth odor?
☐ Yes ☐ No Periodontal "gum problems"?
☐ Yes ☐ No Food impaction between teeth?
☐ Yes ☐ No "Gum boils," frequent canker sores or cold sores?
☐ Yes ☐ No Thumb, finger, or sucking habit? Until what age_____?
☐ Yes ☐ No Abnormal swallowing habit (tongue thrusting)?
☐ Yes ☐ No History of speech problems?
☐ Yes ☐ No Mouth breathing habit, snoring or difficulty in breathing?
☐ Yes ☐ No Tooth grinding or jaw clenching?
☐ Yes ☐ No Any pain or soreness in the muscles of the face or around the ears?
☐ Yes ☐ No Difficulty in chewing or jaw opening?
☐ Yes ☐ No Have you ever been treated for "TMD" or "TMJ" problems?
☐ Yes ☐ No Aware of loose, broken or missing restorations (fillings)?
☐ Yes ☐ No Any teeth irritating cheek, lip, tongue or palate?
☐ Yes ☐ No Concerned about spaces, crooked or protruding teeth?
☐ Yes ☐ No Aware or concerned about under or over developed jaw?
☐ Yes ☐ No Any relative with similar tooth or jaw relationships?
☐ Yes ☐ No Any wisdom teeth problems?
☐ Yes ☐ No Had periodontal (gum) treatment?
☐ Yes ☐ No Had any serious trouble associated with any previous dental treatment?
☐ Yes ☐ No Been under another dentist's care?
Specialist _____
Other _____
☐ Yes ☐ No Ever had a prior orthodontic examination or treatment?
☐ Yes ☐ No Would you object to wearing orthodontic appliances (braces) should they be indicated?

I have read and understand the above questions. I will not hold my orthodontist or any staff member 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 medical/dental status, I will also inform this practice.

Signed: _____ Date Signed: _____ Signed: _____ Date Signed: _____
(Parent or Guardian) (Dental staff member)

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Class _____ Div _____
Open Bite _____ Close Bite _____
A.L. Disc _____ Overjet _____
HABITS: Finger ☐ Thumb ☐ Mouth breather ☐ Tongue Thrust ☐
Eruption Pattern Early ☐ Late ☐

PROFILE: SAT ☐ RETR ☐ FLAT ☐ BIMAX ☐ CONCAVE ☐
LIPS: Together ☐ Apart ☐
CHIN: Protruded ☐ Retruded ☐
NOSE: Aver ☐ Large ☐ Small ☐
ABNORMAL FRENUM: Max ☐ Mand ☐
TMJ Click: Right ☐ Left ☐ Symp ☐ Asymp ☐

TREATMENT
Phase 1 Active Lim Tx

Missing _____/_____
Crossbite _____/_____
Fee Book date
Length of treatment

| Letters | ☐ Referral ☐ Diagnostic ☐ Contract ☐ Completion ☐ ☐ |
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