CONFIDENTIAL

Member
American Association of
Orthodontists

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM - ADULT

Date _____

Patient's Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ Sex _____ Home Phone No. _____

Patient's Address - Street _____

City _____ State _____ Zip Code _____

Patient is Single ☐, Married ☐, Widowed ☐, Separated ☐, Divorced ☐.

Name of spouse/closest relative _____ Phone No. _____

His/Her Address _____ City _____ State _____ Zip _____

Name of Dentist _____

Address _____ Phone No. _____

Name of Physician (s) _____

Address _____ Phone No. _____

Occupation _____ Social Security No. _____ Business Phone No. _____

Insurance coverage yes ___ no ___

Primary Insurance Co. _____ Policy No. _____

Secondary Insurance Co. _____ Policy No. _____

In case we cannot reach you:

Person to contact _____ Phone No. _____

Present Weight _____ Height _____ Musical Instrument Played _____

Favorite Sports, Hobbies & Avocations _____

For the following questions circle yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to 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, mononucleosis, tuberculosis, pneumonia?

yes no dk/u Problems of the immune system?

yes no dk/u Hepatitis, jaundice or liver problem?

yes no dk/u AIDS or HIV Positive?

yes no dk/u Sexually transmitted disease?

yes no dk/u Fainting spells, seizures, epilepsy or neurologic disease?

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 and blue tendency, anemia or bleeding disorder?

yes no dk/u High or low blood pressure?

yes no dk/u Easily tired?