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?

yes no dk/u Chest pain, shortness of breath or swelling ankles?

yes no dk/u **Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?**

yes no dk/u Skin disorder?

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 Do 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 otherwise injured permanent teeth?

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 impaction between teeth?

yes no dk/u "Gum Boils", frequent canker sores, cold sores?

yes no dk/u Thumb, finger, sucking habit? Until _____

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 Do you experience any pain or soreness in the muscles of your face, or around the ears?

yes no dk/u Any pain in jaw or ringing in the ears?

yes no dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)

yes no dk/u Difficulty encountered in chewing or jaw opening?

yes no dk/u History of supernumerary (extra) 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 (fillings)?

yes no dk/u Any teeth irritating cheek, lip, tongue, palate?

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) treatment?

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 dental examination _____

How often do you brush _____ floss _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, 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 medical/dental status, I will so inform this practice.

_____

Signature of patient Date

Medical History Update or Changes: Date: Comments: Signature:

_____

_____

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