**CONFIDENTIAL** ***WELCOME TO OUR OFFICE!***

Date_______________

# MEDICAL HISTORY FORM – ADULT

Patient's Last Name_______________________ First_____________________ Middle_______________

Name I Prefer to be Called___________________ Birthdate________________ Age________ Sex__________

Patient's Home Address___________________________ City_____________ State_______ Zip Code______

Social Security #__________________ Patient is: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Phone #________________ Work Phone #_________________ Cell Phone/Pager #_________________

E-mail (work)________________________________ E-mail (home)_________________________________

Would you like to be reminded of appointments through E-mail? ☐ Yes ☐ No

Name of Spouse/Closest Relative_______________________________ Phone #_______________________

His/Her Address_________________________ City________________ State__________ Zip Code__________

Patient's Dentist_____________________ Address____________________________ Phone #______________

Patient's Physician___________________ Address____________________________ Phone #______________

Occupation_______________ Employer___________________ Address________________________________

Orthodontic Insurance Coverage: ☐ Yes ☐ No

Primary Insurance Co.________________________ Secondary Insurance__________________________

Name of Insured________________ DOB__________ Name of Insured________________ DOB__________

Policy #__________________________________ Policy #_____________________________________

Person to Contact if we can't reach you/ or Emergency__________________________ Home #_____________

Relation______________ Address____________________________________ Work #______________________

Whom may we thank for referring you to us/How did you hear about our office?__________________________

For the following questions please answer **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** Rheumatoid or arthritic conditions?

**Yes no dk/u** Kidney problems?

**Yes no dk/u** Cancer or cancer treatments?

**Yes no dk/u** Polio, mononucleosis?

**Yes no dk/u** Problems of immune system?

**Yes no dk/u** AIDS or HIV positive?

**Yes no dk/u** Mental health or behavioral problems?

**Yes no dk/u** Loss of weight recently, poor appetite?

**Yes no dk/u** High or low blood pressure?

**Yes no dk/u** Skin disorder?

**Yes no dk/u** Bone fractures, any major accidents?

**Yes no dk/u** Endocrine or thyroid problems?

**Yes no dk/u** Diabetes?

**Yes no dk/u** Ulcers, colitis, or hyperacidity?

**Yes no dk/u** Tuberculosis, pneumonia?

**Yes no dk/u** Hepatitis, jaundice. Liver problems?

**Yes no dk/u** Sexually transmitted disease?

**Yes no dk/u** Vision, hearing, tasting, or speech difficulties?

**Yes no dk/u** Anemia, excessive bleeding, bleeding disorder?

**Yes no dk/u** Fainting spells, seizures, epilepsy?

**Yes no dk/u** Neurological problems?

Yes no dk/u Frequent headaches, colds, sore throats?

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

Yes no dk/u Tonsil or adenoid conditions?

Yes no dk/u Allergies or drug reactions?________________

____________________________________

yes no dk/u Taking prescription or non-prescription medication?

____________________________________

Yes no dk/u Drug, alcohol abuse?

Yes no dk/u Are you in good health? Date of most recent physical exam? ____________________

Yes no dk/u Are you taking birth control pills?

Yes no dk/u Eye, ear, nose, throat conditions?

Yes no dk/u **Cardiovascular problems** (heart attack, angina, heart murmur, mitral valve prolapse, stroke, heart defects, rheumatic heart, pacemaker?)

yes no dk/u Operations?______________________________

Yes no dk/u Hospitalized? For__________________________

yes no dk/u Hay fever, allergies?

Yes no dk/u Being treated by another health care professional? For______________________________

yes no dk/u Are you pregnant?

Yes no dk/u Are you anticipating becoming pregnant?

## DENTAL HISTORY

What are the main concerns that brought you to our office/What don't you like about your smile or bite?__________________________

______________________________________________________________________

Yes no dk/u Have you ever been treated by an orthodontist before? Orthodontist______________________________

Yes no dk/u Have you had an orthodontic evaluation before? Date______________________________

Yes no dk/u Chipped or injured permanent teeth?

Yes no dk/u Jaw fractures, cysts, mouth infections?

Yes no dk/u Periodontal "gum problems"?

Yes no dk/u Canker sores, cold sores?

Yes no dk/u Abnormal swallowing (tongue thrusting)?

Yes no dk/u Teeth grinding, jaw clenching?

Yes no dk/u Pain/soreness in muscles of face, or around ears?

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

Yes no dk/u Difficulty in chewing or jaw opening?

Yes no dk/u Have any permanent teeth been removed?

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

Yes no dk/u Concerned about under or over developed jaw?

Yes no dk/u Any wisdom tooth problems?

Yes no dk/u Teeth sensitive to hot or cold?

Yes no dk/u "Dead Teeth", root canals treated?

yes no dk/u Food impaction between teeth?

Yes no dk/u Thumb, finger, sucking habit?

Yes no dk/u Mouth breathing, snoring, difficulty breathing?

Yes no dk/u Head, neck pain?

Yes no dk/u Clicking, popping, or locking of jaw?

Yes no dk/u Ever been treated for "TMJ" problems?

Yes no dk/u History of "extra" teeth or missing teeth?

Yes no dk/u Aware of loose, broken, or missing fillings?

Yes no dk/u Concerned about spaced, crooked, protruding teeth?

Yes no dk/u Any relative with similar tooth or jaw problem?

Yes no dk/u Are you self-conscious about your profile?

Date of last dental examination________________How often do you brush________________How often do you floss______________

Realizing that successful treatment greatly depends on 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