Adult Medical and Dental History

Medical History:

Your Name: ______________________________
Name of Physician: ______________________ Phone Number ______________
Location (city): ______________________ Last Visit: ____________________

Current physical health is: Good Fair Poor
Are you currently under the care of a doctor? Y N Reason: ______________
____

Are you taking any prescription medications? Y N
Please list: ____

Have you ever had any of the following diseases or medical problems? (Please circle Y or N)

Y N Heart murmur
Y N Rheumatic fever
Y N Mitral valve prolapse
Y N Heart surgery/ Pacemaker
Y N Congenital heart defect
Y N Heart attack
Y N Artificial heart valves
Y N Fever blister
Y N Ulcer/Colitis
Y N Sinus problems
Y N Abnormal bleeding
Y N Kidney problems
Y N Liver problems
Y N Facial pain
Y N Drug/Alcohol abuse
Y N Glaucoma
Y N Injury to head or neck
Y N Major surgeries
Y N Artificial joints
Y N Arthritis
Y N HIV/AIDS
Y N Cancer, radiation treatment, chemotherapy
Y N Allergies/Hay fever
Y N Diabetes
Y N Hemophilia
Y N Hepatitis
Y N Shingles
Y N Acid reflux
Y N Emphysema
Y N Convulsions/Epilepsy
Y N Tuberculosis
Y N Sev/Freq. Headaches
Y N Hi/Lo blood pressure
Y N Blood transfusion
Y N Difficulty breathing/ Asthma
Y N Unusual growth pattern
Y N Thyroid problems
Y N Eye, ear, nose or throat condition
Y N Pituitary problems
Y N Mental health disturbance or depression

If yes to any of the above questions, please explain: ____________________________
____
____

Any other medical condition that we should know about? Y N ______________________

Do you smoke or use tobacco products? Y N

Are you allergic to any medications? Y N Please list: ____________________
Are you allergic to (please circle):

Y N Latex
Y N Nickel or other metals
Y N Dental anesthetics
Y N Plastics/acrylics
Y N Food ____________________
Y N Other ____________________

FOR WOMEN ONLY:
Are you taking birth control pills? Y N
Are you pregnant? Month#_____ Y N
Are you nursing? Y N

Dental History:

Dentist's Name: ______________________________
Location (city): ______________________________
Date of last visit: ______________________________

What is the main concern that you would like orthodontics to accomplish?
____

Current dental health is: Good Fair Poor

Have you ever had a serious problem associated with dental work? Y N
If yes, please explain:____

Has a doctor told you that you need to take antibiotics or any other medications before dental work? Y N
If yes, please explain: ____

Have you ever had any pain, tenderness, or locking in the jaw joint, or jaw muscles (TMJ/TMD)? Y N

Have you ever had any of the following? (Please circle Y or N)

Y N Gum disease
Y N Previous orthodontic treatment
Y N Recurrent pain in mouth
Y N Speech problems
Y N Sores, lumps or irritated areas
Y N Grinding of teeth
Y N Permanent teeth extracted
Y N Recurrent tooth pain
Y N Unfinished dental treatment
Y N Clenching of teeth
Y N Other:

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

____
Signature Date