American Association of Orthodontists

Date: _____

CONFIDENTIAL

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM – ADULT

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

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐ I Prefer To Be Called: _____

S.S.N./S.I.N.: _____ Home Phone No.: (___)___-____ E-mail address: _____

Cell phone number:_____Pager number:_____

Patient's Address: _____

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

Years at above address: ____

If less than 5 years at current address, previous address:_____

Years at previous address: _____ Patient is: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____ Employer:_____ Years with Employer: ____

Business Phone No.: (_____)_____-_____

Name Of Spouse/Closest Relative: _____ Phone No.: (if different than yours) (_____)_____-_____

Relationship To You: _____

Address (if different than yours): _____

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

Name Of Patient's Dentist: _____ Phone No.: (_____)_____-_____

Dentist's Address: _____

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

Date Last Seen: _____ Reason: _____

Name Of Patient's Physician(s): _____ Phone No(s).: (___)___-____

Physician's Address: _____

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

Date Last Seen: _____ Reason: _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Who Is Financially Responsible For This Account?

Last Name: _____ First Name: _____ Middle Name/Initial: _____

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

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

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

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

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No. _____

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

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No. _____

Medical Insurance Company: _____

For the following questions mark 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

Now or in the past, have you had:

☐**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, tumor, radiation treatment or chemotherapy?
☐**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** AIDS or HIV positive?
☐**yes** ☐**no** ☐**dk/u** Hepatitis, jaundice or liver problem?
☐**yes** ☐**no** ☐**dk/u** Fainting spells, seizures, epilepsy or neurological problem?
☐**yes** ☐**no** ☐**dk/u** Mental health disturbance or depression?
☐**yes** ☐**no** ☐**dk/u** Vision, hearing, tasting or speech difficulties?
☐**yes** ☐**no** ☐**dk/u** Loss of weight recently, poor appetite?
☐**yes** ☐**no** ☐**dk/u** History of eating disorder (anorexia, bulimia)?
☐**yes** ☐**no** ☐**dk/u** Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐**yes** ☐**no** ☐**dk/u** High or low blood pressure?
☐**yes** ☐**no** ☐**dk/ u** Tired easily?
☐**yes** ☐**no** ☐**dk/u** Chest pain, shortness of breath or swelling ankles?
☐**yes** ☐**no** ☐**dk/u** Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐**yes** ☐**no** ☐**dk/u** Skin disorder?
☐**yes** ☐**no** ☐**dk/u** Do you have a well-balanced diet?
☐**yes** ☐**no** ☐**dk/u** Frequent headaches, colds or sore throats?
☐**yes** ☐**no** ☐**dk/u** Eye, ear, nose or throat condition?
☐**yes** ☐**no** ☐**dk/u** Hayfever, asthma, sinus trouble or hives?
☐**yes** ☐**no** ☐**dk/u** Tonsil or adenoid conditions?
☐**yes** ☐**no** ☐**dk/u** Osteoporosis?

Allergies or reactions to any of the following:

☐**yes** ☐**no** ☐**dk/u** Local anesthetics (Novocaine or Lidocaine)
☐**yes** ☐**no** ☐**dk/u** Aspirin
☐**yes** ☐**no** ☐**dk/u** Ibuprofen (Motrin, Advil)
☐**yes** ☐**no** ☐**dk/u** Penicillin or other antibiotics
☐**yes** ☐**no** ☐**dk/u** Sulfa drugs
☐**yes** ☐**no** ☐**dk/u** Codeine or other narcotics
☐**yes** ☐**no** ☐**dk/u** Metals (jewelry, clothing snaps)
☐**yes** ☐**no** ☐**dk/u** Latex (gloves, balloons)
☐**yes** ☐**no** ☐**dk/u** Vinyl
☐**yes** ☐**no** ☐**dk/u** Acrylic
☐**yes** ☐**no** ☐**dk/u** Animals
☐**yes** ☐**no** ☐**dk/u** Foods (specify) _____
☐**yes** ☐**no** ☐**dk/u** Other substances (specify) _____

☐**yes** ☐**no** ☐**dk/u** Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

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

☐**yes** ☐**no** ☐**dk/u** Do you currently have or ever had a substance abuse problem?
☐**yes** ☐**no** ☐**dk/u** Do you chew or smoke tobacco?
☐**yes** ☐**no** ☐**dk/u** Operations? Describe: _____
☐**yes** ☐**no** ☐**dk/u** Hospitalized? For: _____
☐**yes** ☐**no** ☐**dk/u** Other physical problems or symptoms? Describe: _____
☐**yes** ☐**no** ☐**dk/ u** 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** ☐**dk/u** Are you pregnant?
☐**yes** ☐**no** ☐**dk/u** Are you anticipating becoming pregnant?

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 imbalance_____
Any other family medical conditions that we should know about? _____

DENTAL HISTORY

Now or in the past, has the patient had:

☐**yes** ☐**no** ☐**dk/u** Permanent or "extra" (supernumerary) teeth removed?

☐**yes** ☐**no** ☐**dk/u** Supernumerary (extra) or congenitally missing teeth?

☐**yes** ☐**no** ☐**dk/u** Chipped or otherwise injured primary (baby) or permanent teeth?

☐**yes** ☐**no** ☐**dk/u** Teeth sensitive to hot or cold; teeth throb or ache?

☐**yes** ☐**no** ☐**dk/u** Jaw fractures, cysts or mouth infections?

☐**yes** ☐**no** ☐**dk/u** "Dead teeth" or root canals treated?

☐**yes** ☐**no** ☐**dk/u** Bleeding gums, bad taste or 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 or cold sores?

☐**yes** ☐**no** ☐**dk/u** Thumb, finger, or sucking habit? Until what age _____?

☐**yes** ☐**no** ☐**dk/u** Abnormal swallowing habit (tongue thrusting)?

☐**yes** ☐**no** ☐**dk/u** History of speech problems?

☐**yes** ☐**no** ☐**dk/u** Mouth breathing habit, snoring or difficulty in breathing?

☐**yes** ☐**no** ☐**dk/u** Tooth grinding or jaw clenching?

☐**yes** ☐**no** ☐**dk/u** Any pain, clicking or locking in jaw or ringing in the ears?

☐**yes** ☐**no** ☐**dk/u** Any pain or soreness in the muscles of the face or around the ears?

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

☐**yes** ☐**no** ☐**dk/u** Have you ever been treated for "TMD" or "TMJ" problems?

☐**yes** ☐**no** ☐**dk/u** Aware of loose, broken or missing restorations (fillings)?

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

☐**yes** ☐**no** ☐**dk/u** Concerned about spaced, crooked or 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** Had periodontal (gum) treatment?

☐**yes** ☐**no** ☐**dk/u** Had any serious trouble associated with any previous dental treatment?

☐**yes** ☐**no** ☐**dk/u** Been under another dentist's care?
Specialist _____
Other _____

☐**yes** ☐**no** ☐**dk/u** Ever had a prior orthodontic examination or treatment?

☐**yes** ☐**no** ☐**dk/u** Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: _____ floss: _____

What is your primary concern? Why are you here? _____

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.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date Signed: _____
(Patient)
Signed:_____ Date Signed: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date Signed: _____
(Patient)

Signed:_____ Date Signed: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date Signed: _____
(Patient)
Signed:_____ Date Signed: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____
Signed: _____ Date Signed: _____
(Patient)
Signed:_____ Date Signed: _____
(Dental Staff Member)