ADULT MEDICAL HISTORY FORM

ABOUT YOU

Name _____
Last First MI

I prefer to be called _____ ☐ Male ☐ Female

Birthdate _____ / _____ / _____ Age _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary Phone # _____

Cell Phone # _____

Address: _____

_____

Occupation/Employer_____ / _____

Other family members seen by us: _____

How did you hear about us? _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

SPOUSE INFORMATION (IF APPLICABLE)

Name _____
Last First MI

Birthdate. _____ / _____ / _____ ☐ Male ☐ Female

Phone # _____

MEDICAL AND DENTAL HISTORY

Who is your General Dentist? _____

Estimated date of your last cleaning and checkup _____

What are the main goals that you would like to accomplish with your orthodontic treatment? _____

_____

Do you have any pending or unfinished dental work?

☐ Yes ☐ No If yes describe _____

Have you ever had an orthodontic consultation?

☐ Yes ☐No

Have you ever had a problem with any previous dental work?

☐ Yes ☐No

How would you describe your current dental health?

☐ Good ☐ Fair ☐ Poor

Do you brush and floss regularly?

☐ Yes ☐ No

Have you ever had an injury to your mouth, teeth, or jaws?

☐ Yes ☐ No

Do you now or have you ever experienced pain, discomfort, or abnormal sounds coming from your jaw joint? (TMJ/TMD)?

☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No
If yes please explain _____
Physician's name _____
Are you currently taking any over the counter or prescription drugs?

☐ Yes ☐ No If yes please list _____

Have you ever had any of the following procedures or conditions?

☐ Yes ☐ No Abnormal Bleeding
☐ Yes ☐ No Anemia
☐ Yes ☐ No Artificial Bone/Joints/Valves
☐ Yes ☐ No Asthma
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Cancer/Chemotherapy
☐ Yes ☐ No Congenital Heart Defects
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Difficulty Breathing
☐ Yes ☐ No Drug/ Alcohol Abuse
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Epilepsy/ Seizures/ Fainting
☐ Yes ☐ No Fever Blisters/ Herpes
☐ Yes ☐ No Heart Murmur/ Mitral Valve Prolapse
☐ Yes ☐ No Heart Surgery/ Pacemaker
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No High/ Low Blood Pressure
☐ Yes ☐ No HIV+/AIDS
☐ Yes ☐ No Hospitalization
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Psychiatric Problems
☐ Yes ☐ No Rheumatic/Scarlet Fever
☐ Yes ☐ No Shingles
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Severe/ Frequent Headaches
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Ulcers/ Colitis
☐ Yes ☐ No Other _____

Are you allergic to any of the following?

☐ Yes ☐ No Aspirin
☐ Yes ☐ No Dental Anesthetics
☐ Yes ☐ No Latex
☐ Yes ☐ No Metal/Nickel
☐ Yes ☐ No Antibiotics? Specify: _____
☐ Yes ☐ No Other? Specify: _____

Women only. Are you currently:

☐ Yes ☐ No Pregnant Week# _____
☐ Yes ☐ No Nursing
☐ Yes ☐ No Taking birth control

I understand that the information I have provided is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
DOCTOR SIGNATURE **DATE**