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 currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/cancers: such as Zometa (zolendronic acid), Aredia (pamidronate), Didronel (etidronate)?

☐yes ☐no ☐dk/u Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses: such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate) Skelid (tiludronate), Didronel (etidronate)?

☐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? _____

Questions: _____

DOCTOR CONTACT INFORMATION

Doctor's Last Name: _____ First Name: _____ Middle Name/Initial: ____

Office Phone No.: (___)___-____ E-mail address: _____

Doctor's Address: _____

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

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)