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)? Please name the medication and length of time on the medication.

Medication _____ Length of time taken _____
Medication _____ Length of time taken _____

☐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? Describe:_____
_____
☐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, have you 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)