

Medical Dental History Form for Adult Patients

Date _____

Patient's Last Name Patient's First Name _____

Birth Date _____

Patient's Mailing Address _____

Patient's Email Address _____

Dentist Name _____ Dentist Phone Number _____

What concerns you about your teeth?

Who suggest that you might need orthodontic treatment?

Medical History

Birth Defect or Hereditary Problem? Yes No

Bone Fractures or major injuries? Yes No

Any injuries to face, head, neck? Yes No

Arthritis or joint problem? Yes No

Endocrine or thyroid Problems? Yes No

Diabetes or low sugar? Yes No

Kidney Problem? Yes No

Cancer, tumor, radiation treatment or chemotherapy? Yes No

Stomach ulcer, hyperacidity, acid reflux? Yes No

Immune system problem? Yes No

History of osteoporosis? Yes No

Gonorrhea, syphilis, herpes, sexually transmitted diseases? Yes No

AIDS or HIV positive? Yes No

Hepatitis, jaundice, or other liver problem? Yes No

Polio, mononucleosis, tuberculosis, pneumonia? Yes No

Seizures, Fainting spells, neurologic problems? Yes No

Mental health disturbance or depression? Yes No

Visio, hearing or speech problems? Yes No

- History of eating disorder? Yes No
- High or low blood pressure? Yes No
- Excessive bleeding or bruising, anemia? Yes No
- Chest pain, shortness of breath, tire easily, swollen ankles? Yes No
- Heart defects, heart murmur, rheumatic heart disease? Yes No
- Angina, arteriosclerosis, stroke, or heart attack? Yes No
- Skin disorder? Yes No
- Do you eat a well-balanced diet? Yes No
- Frequent headaches or migraines? Yes No
- Frequent ear infections, colds, throat infections? Yes No
- Asthma, sinus problems, hayfever? Yes No
- Tonsil or adenoid condition? Yes No
- Do you frequently breathe through mouth? Yes No
- Do you snore? Yes No
- Has your snoring ever bothered anyone? Yes No
- Has anyone noticed that you stop breathing during your sleep? Yes No
- Do you feel fatigued or tired after your sleep? Yes No
- During your waking time, do you feel tired, or fatigued? Yes No
- Have you ever fallen asleep while driving a vehicle? Yes No

Have you had allergies or reactions to any of the following?

- Local anesthetics (novocaine, lidocaine, xylocaine) Yes No
- Latex (gloves, balloons) Yes No
- Aspirin Yes No
- Metals (jewelry, clothing snaps) Yes No
- Penicillin Yes No
- Other antibiotics Yes No
- Ibuprofen (Motrin, Advil), Acrylics Yes No
- Plant pollens Yes No
- Animals Yes No
- Foods Yes No

Dental History

- Permanent or extra (supernumerary) teeth removed? Yes No
- Supernumerary (extra) or congenitally missing teeth? Yes No
- Chipped or injured primary or permanent teeth? Yes No
- Any sensitive or sore teeth? Yes No
- Bleeding gums, bad taste or mouth odor? Yes No
- Jaw fractures, cysts, infections? Yes No
- Any teeth, treated with root canals or pulpotomies? Yes No
- Gum boils, frequent cancer sores or cold sores? Yes No
- History of speech problems or speech therapy? Yes No
- Difficulty breathing through nose? Yes No
- Food impaction between the teeth? Yes No
- Mouth breathing habit or snoring at night? Yes No
- Frequent oral habits (sucking finger, chewing pen)? Yes No
- Teeth causing irritation to lip, cheek or gums? Yes No
- Abnormal swallowing (tongue thrust)? Yes No
- Tooth grinding or clenching? Yes No
- Clicking, locking in jaw joints? Yes No
- Soreness in jaw muscles or face muscles? Yes No
- Ringling in ears, difficulty in chewing or opening jaw? Yes No
- Have you ever been treated for TMJ or TMD problems? Yes No
- Any broken or missing fillings? Yes No
- Any serious trouble associated with previous dental treatment? Yes No
- Have you ever been diagnosed with gum disease? Yes No
- Have you ever had an orthodontic consultation or treatment before now? Yes No

List of any Medications:

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental or medical

insurance company.

Signature:

_____ Patient Full Name _____ Patient Signature _____ Date

Date: _____