



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 (zoledronic 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"?

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)

- 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?

**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)