HUDSON
ORTHODONTICS FOR ALL AGES

CONFIDENTIAL **DATE_____**

American Association of Orthodontics
MEDICAL DENTAL HISTORY FORM-ADULT

Patient's Last Name:_____First Name:_____ Initial:_____

Birthdate_____ Age_____ Biological Sex: Male____ Female____

Name of Spouse/Closest relative:_____ Phone #:_____

Relationship to You:_____

Address (if different than yours):_____

City:_____ State:_____ Zip:_____

***What Concerns YOU about your teeth?*_____**

Name of Patient's DENTIST:_____ Phone#:_____

Dentist Address:_____

City: _____ State:_____ Zip:_____

Date Last Seen:_____ Reason:_____

Name of Patient's PHYSICIAN:_____ Phone#:_____

Address:_____

City: _____ State:_____ Zip:_____

Date Last Seen:_____ Reason:_____

Your answers are for office records only and are confidential. A thorough medical history is essential to complete an orthodontic evaluation. For the following questions, please mark yes, no, or don't know/understand (dk/u). If there is more than one option, please circle the correct one or write in at the bottom. Thanks

If you mark "YES, please explain.

MEDICAL HISTORY

Now or in the past, have you had:

☐Yes ☐No ☐dk/u Birth defects or heredity problems?
☐Yes ☐No ☐dk/u Bone fractures/major injuries? _____
☐Yes ☐No ☐dk/u Injuries to head, face, neck? _____
☐Yes ☐No ☐dk/u Arthritis or joint problems?
☐Yes ☐No ☐dk/u Cancer, tumor, radiation or chemotherapy?
☐Yes ☐No ☐dk/u Endocrine or thyroid problems? _____
☐Yes ☐No ☐dk/u Diabetes or low sugar?
☐Yes ☐No ☐dk/u Kidney problems? _____
☐Yes ☐No ☐dk/u Immune system problems?
☐Yes ☐No ☐dk/u History of osteoporosis?

☐Yes ☐No ☐dk/u Hepatitis, jaundice, or other liver problems?
☐Yes ☐No ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐Yes ☐No ☐dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases'?
☐Yes ☐No ☐dk/u Heart defects, heart murmur, rheumatic heart disease?
☐Yes ☐No ☐dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
☐Yes ☐No ☐dk/u Mental health disturbance?
☐Yes ☐No ☐dk/u History of eating disorder (anorexia, bulimia)?
☐Yes ☐No ☐dk/u Acid reflux, Gerd
☐Yes ☐No ☐dk/u High or low blood pressure? (Circle one)
☐Yes ☐No ☐dk/u Excessive bleeding/bruising tendency, anemia?
☐Yes ☐No ☐dk/u Vision, hearing, or speech problems?
☐Yes ☐No ☐dk/u Angina, arteriosclerosis, stroke or heart attack?
☐Yes ☐No ☐dk/u Skin disorder (other than common acne)?
☐Yes ☐No ☐dk/u Do you eat a well balanced diet?
☐Yes ☐No ☐dk/u Frequent headaches or migraines?
☐Yes ☐No ☐dk/u Frequent ear infections, colds, throat problems?
☐Yes ☐No ☐dk/u Asthma, sinus problems, hay fever?
☐Yes ☐No ☐dk/u Tonsils or adenoid condition?
☐Yes ☐No ☐dk/u Do you frequently breathe through your mouth?
☐Yes ☐No ☐dk/u AIDS or HIV positive?
☐Yes ☐No ☐dk/u Depression, anxiety

Other/ explain _____

_____

_____

_____

ALLERGIES

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

☐Yes ☐No ☐dk/u Local anesthetics (Novocain, Lidocaine)
☐Yes ☐No ☐dk/u Latex (Gloves, balloons)
☐Yes ☐No ☐dk/u Aspirin
☐Yes ☐No ☐dk/u Ibuprofen (Motrin, Advil)
☐Yes ☐No ☐dk/u Penicillin
☐Yes ☐No ☐dk/u Other antibiotics
☐Yes ☐No ☐dk/u Metals (jewelry, clothing, nickel)
☐Yes ☐No ☐dk/u Acrylics
☐Yes ☐No ☐dk/u Plant pollens
☐Yes ☐No ☐dk/u Animals
☐Yes ☐No ☐dk/u Food _____
☐Yes ☐No ☐dk/u Other substances
_____

DENTAL HISTORY

Now or in the past, have you had:

☐Yes ☐No ☐dk/u Had an orthodontic consultation before?
☐Yes ☐No ☐dk/u Permanent/extra teeth removed?
☐Yes ☐No ☐dk/u Extra or missing permanent/adult teeth?
☐Yes ☐No ☐dk/u Chipped or injured primary/permanent teeth?
☐Yes ☐No ☐dk/u Any sensitive or sore teeth?
☐Yes ☐No ☐dk/u Bleeding gums, bad taste or mouth odor?
☐Yes ☐No ☐dk/u Jaw fractures, cysts, infections?
☐Yes ☐No ☐dk/u Any lost or broken fillings?
☐Yes ☐No ☐dk/u Frequent canker sores or cold sores?
☐Yes ☐No ☐dk/u History of speech problems or speech therapy?
☐Yes ☐No ☐dk/u Difficulty breathing through nose?
☐Yes ☐No ☐dk/u Do you snore at night?
☐Yes ☐No ☐dk/u Food impaction between teeth?
☐Yes ☐No ☐dk/u Frequent oral habits?
☐Yes ☐No ☐dk/u Teeth causing irritation to lip, cheek or gums?
☐Yes ☐No ☐dk/u Tooth grinding or clenching?
☐Yes ☐No ☐dk/u Clicking, locking in jaw joints?
☐Yes ☐No ☐dk/u Soreness in jaw or face muscles?
☐Yes ☐No ☐dk/u Ringing in ears?
☐Yes ☐No ☐dk/u Difficulty in chewing or opening jaw?
☐Yes ☐No ☐dk/u Any serious trouble with previous dental treatment?
☐Yes ☐No ☐dk/u Ever been diagnosed with gum disease?

ADDITIONAL HISTORY:

Now or in the past, have you had:

☐Yes ☐No ☐dk/u MRSA?
☐Yes ☐No ☐dk/u Have you ever taken intravenous bisposphonates such as Zometa, Aredia, or Didronel for bone disorders or cancer?
☐Yes ☐No ☐dk/u Have you ever taken oral bisphosphonates such as Fosomax, Actonel, Boniva, Skelid, or Didronel for bone disorders?

PATIENT HEALTH INFORMATION

List any medications, nutritional supplements, herbal medications or non-prescription medicines, including fluoride, supplements that you take.

Medication _____ Taken for_____
Medication _____ Taken for_____
Medication _____ Taken for_____
Medication _____ Taken for_____
Medication _____ Taken for_____
Medication _____ Taken for_____
Medication _____ Taken for_____
Medication _____ Taken for_____

Have you ever taken any medication to strengthen your bones? Please describe_____

Do you or have you ever had a substance abuse problem? _____
Do you chew or smoke tobacco? _____
Have you noticed any changes in your face or jaws? _____
Any other physical problems? _____
How often do you brush? _____
How often do you floss? _____
Women: Are you pregnant? _____ Yes _____ No Are you trying to become pregnant? _____ Yes _____ No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Sleep Apnea/ CPAP/ Snoring _____
Bleeding disorders _____
Diabetes_____
Arthritis_____
Severe allergies_____
Unusual dental problems_____
Jaw size imbalance _____
Other family medical conditions _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date: _____

I have read the above questions and understand them. I will not hold my orthodontist or any of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date: _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes ____ Yes ____ No
Patient signature _____ Date _____
Dental Staff Signature _____ Date _____

Changes ____ Yes ____ No
Patient signature _____ Date _____
Dental Staff Signature _____ Date _____

Changes ____ Yes ____ No
Patient signature _____ Date _____
Dental Staff Signature _____ Date _____

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