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/Genetic 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:_____

CONFIDENTIAL

A thorough medical history is essential to an orthodontic evaluation. For the following questions, please mark yes, no, or don't know (dk). If there is more than one option, please circle the correct one or write in at the bottom.

If you mark "YES, please explain.

MEDICAL HISTORYALLERGIES

Now or in the past, have you had: Have you had reactions to any of the following?

☐Yes ☐No ☐dk Birth defects or heredity problems? (Explain Below)☐Yes ☐No ☐dkLocal anesthetics (Novocaine, Lidocaine)

☐Yes ☐No ☐dkBone fractures/major injuries? (Explain Below) ☐Yes ☐No ☐dkLatex (Gloves, balloons)

☐Yes ☐No ☐dkInjuries to head, face, neck? (Explain Below) ☐Yes ☐No ☐dkAspirin

☐Yes ☐No ☐dkArthritis or joint problems? (Explain Below) ☐Yes ☐No ☐dkIbuprofen (Motrin, Advil)

☐Yes ☐No ☐dkCancer, tumor, radiation or chemotherapy? ☐Yes ☐No ☐dkPenicillin, Amoxicillin

☐Yes ☐No ☐dkEndocrine or thyroid problems? (Explain Below) ☐Yes ☐No ☐dkOther antibiotics

☐Yes ☐No ☐dkDiabetes or low sugar? ☐Yes ☐No ☐dkMetals (jewelry, clothing, nickel)

☐Yes ☐No ☐dkKidney problems? (Explain Below) ☐Yes ☐No ☐dkAcrylics

☐Yes ☐No ☐dkImmune system problems? (Explain Below)☐Yes ☐No ☐dkPlant pollens

☐Yes ☐No ☐dkOsteoporosis or taking bone medications? (Explain Below)☐Yes ☐No ☐dkAnimals

☐Yes ☐No ☐dkSkin disorder (other than common acne)?☐Yes ☐No ☐dkFood _____

☐Yes ☐No ☐dkHepatitis, jaundice, or liver problems? (Explain Below) ☐Yes ☐No ☐dkOther substances:

☐Yes ☐No ☐dkPolio, mononucleosis, tuberculosis, pneumonia? _____

☐Yes ☐No ☐dkGonorrhea, syphilis, herpes, sexually transmitted infections?

☐Yes ☐No ☐dkHeart defects, heart murmur, rheumatic heart disease? (Explain Below)

☐Yes ☐No ☐dkChest pain, shortness of breath, tire easily, swollen ankles? **DENTAL HISTORY**

☐Yes ☐No ☐dkMental health issue? _____ Now or in the past, have you had:

☐Yes ☐No ☐dkEating disorder (anorexia, bulimia, etc)?(Explain Below) ☐Yes ☐No ☐dk Any lost or broken fillings?

☐Yes ☐No ☐dkAcid Reflux or GERD? (Explain Below) ☐Yes ☐No ☐dk Had an orthodontic consultation before?

☐Yes ☐No ☐dkHigh or low blood pressure? (Circle one) ☐Yes ☐No ☐dk Permanent/extra teeth removed?

☐Yes ☐No ☐dkExcessive bleeding/bruising tendency, anemia? ☐Yes ☐No ☐dk Extra or missing permanent/adult teeth?

☐Yes ☐No ☐dkVision, hearing, or speech problems? ☐Yes ☐No ☐dk Chipped or injured teeth?

☐Yes ☐No ☐dkAngina, arteriosclerosis, stroke or heart attack? ☐Yes ☐No ☐dk Any sensitive or sore teeth?

☐Yes ☐No ☐dkAIDS or HIV positive? ☐Yes ☐No ☐dk Bleeding gums, bad taste or mouth odor?

☐Yes ☐No ☐dkDo you eat a well balanced diet? ☐Yes ☐No ☐dk Jaw fractures, cysts, infections?

☐Yes ☐No ☐dkFrequent headaches or migraines? (Explain Below) ☐Yes ☐No ☐dk Ever been diagnosed with gum disease?

☐Yes ☐No ☐dkFrequent ear infections, colds, throat problems? ☐Yes ☐No ☐dk Frequent canker sores or cold sores?

☐Yes ☐No ☐dkAsthma, sinus problems, hay fever? ☐Yes ☐No ☐dk History of speech problems or therapy?

☐Yes ☐No ☐dkTonsils or adenoid condition? (Explain Below) ☐Yes ☐No ☐dk Difficulty breathing through nose?

☐Yes ☐No ☐dkDo you frequently breathe through your mouth? ☐Yes ☐No ☐dk Do you snore at night?

☐Yes ☐No ☐dkWeight loss medication (Wegovy, Ozempic, etc.)? ☐Yes ☐No ☐dk Food impaction between teeth?

☐Yes ☐No ☐dk Frequent oral habits? _____

☐Yes ☐No ☐dk Teeth causing irritation to lip, cheek or gums?

OTHER/EXPLANATION:_____ ☐Yes ☐No ☐dk Tooth grinding or clenching?

☐Yes ☐No ☐dk Clicking, locking in jaw joints?

_____ ☐Yes ☐No ☐dk Soreness in jaw or face muscles?

☐Yes ☐No ☐dk Ringing in ears?

_____ ☐Yes ☐No ☐dk Difficulty in chewing or opening jaw?

☐Yes ☐No ☐dk Any serious trouble with previous dental work?

_____

_____

ADDITIONAL HISTORY:

Now or in the past, have you had:

☐Yes ☐No ☐dk MRSA?

☐Yes ☐No ☐dk Have you ever taken intravenous bisposphonates such as Zometa, Aredia, or Didronel for bone disorders or cancer?

☐Yes ☐No ☐dk Have you ever taken oral bisphosphonates such as Fosomax, Actonel, Boniva, Skelid, or Didronel for bone disorders?

☐Yes ☐No ☐dk Have a condition that requires antibiotics before dental procedures? _____

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_____

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-Due Date___/___/___ No___ 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 _____