



MEDICAL AND DENTAL HISTORY FORM- ADULT

DATE _____

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

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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 HISTORY

Now or in the past, have you had:

- Yes No dk Birth defects or heredity problems? (Explain Below)
- Yes No dk Bone fractures/major injuries? (Explain Below)
- Yes No dk Injuries to head, face, neck? (Explain Below)
- Yes No dk Arthritis or joint problems? (Explain Below)
- Yes No dk Cancer, tumor, radiation or chemotherapy?
- Yes No dk Endocrine or thyroid problems? (Explain Below)
- Yes No dk Diabetes or low sugar?
- Yes No dk Kidney problems? (Explain Below)
- Yes No dk Immune system problems? (Explain Below)
- Yes No dk Osteoporosis or taking bone medications? (Explain Below)
- Yes No dk Skin disorder (other than common acne)?
- Yes No dk Hepatitis, jaundice, or liver problems? (Explain Below)
- Yes No dk Polio, mononucleosis, tuberculosis, pneumonia?
- Yes No dk Gonorrhea, syphilis, herpes, sexually transmitted infections?
- Yes No dk Heart defects, heart murmur, rheumatic heart disease? (Explain Below)
- Yes No dk Chest pain, shortness of breath, tire easily, swollen ankles?
- Yes No dk Mental health issue? _____
- Yes No dk Eating disorder (anorexia, bulimia, etc)?(Explain Below)
- Yes No dk Acid Reflux or GERD? (Explain Below)
- Yes No dk High or low blood pressure? (Circle one)
- Yes No dk Excessive bleeding/bruising tendency, anemia?
- Yes No dk Vision, hearing, or speech problems?
- Yes No dk Angina, arteriosclerosis, stroke or heart attack?
- Yes No dk AIDS or HIV positive?
- Yes No dk Do you eat a well balanced diet?
- Yes No dk Frequent headaches or migraines? (Explain Below)
- Yes No dk Frequent ear infections, colds, throat problems?
- Yes No dk Asthma, sinus problems, hay fever?
- Yes No dk Tonsils or adenoid condition? (Explain Below)
- Yes No dk Do you frequently breathe through your mouth?
- Yes No dk Weight loss medication (Wegovy, Ozempic, etc.)?
- Yes No dk Medications give you dry mouth? Xerostomia?

OTHER/EXPLANATION:

ALLERGIES

Have you had reactions to any of the following?

- Yes No dk Local anesthetics (Novocaine, Lidocaine)
- Yes No dk Latex (Gloves, balloons)
- Yes No dk Aspirin
- Yes No dk Ibuprofen (Motrin, Advil)
- Yes No dk Penicillin, Amoxicillin
- Yes No dk Other antibiotics
- Yes No dk Metals (jewelry, clothing, nickel)
- Yes No dk Acrylics
- Yes No dk Plant pollens
- Yes No dk Animals
- Yes No dk Food _____
- Yes No dk Other substances: _____

DENTAL HISTORY

Now or in the past, have you had:

- Yes No dk Any lost or broken fillings?
- Yes No dk Had an orthodontic consultation before?
- Yes No dk Permanent/extra teeth removed?
- Yes No dk Extra or missing permanent/adult teeth?
- Yes No dk Chipped or injured teeth?
- Yes No dk Any sensitive or sore teeth?
- Yes No dk Bleeding gums, bad taste or mouth odor?
- Yes No dk Jaw fractures, cysts, infections?
- Yes No dk Ever been diagnosed with gum disease?
- Yes No dk Frequent canker sores or cold sores?
- Yes No dk History of speech problems or therapy?
- Yes No dk Difficulty breathing through nose?
- Yes No dk Do you snore at night?
- Yes No dk Food impaction between teeth?
- Yes No dk Frequent oral habits? _____
- Yes No dk Teeth causing irritation to lip, cheek or gums?
- 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 bisphosphonates 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 _____

Do you or have you ever had a substance abuse problem? _____

Do you chew, smoke, and/or vape 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 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 _____

Changes ___ Yes ___ No

Patient signature _____ Date _____

Dental Staff Signature _____ Date _____