



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)?

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? For: \_\_\_\_\_

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, has the patient had:

- |     |    |      |   |     |    |      |   |
|-----|----|------|---|-----|----|------|---|
| yes | no | dk/u | Permanent or "extra" (supernumerary) teeth removed?             | yes | no | dk/u | Any pain or soreness in the muscles of the face or around the ears?                   |
| yes | no | dk/u | Supernumerary (extra) or congenitally missing teeth?            | yes | no | dk/u | Difficulty in chewing or jaw opening?   |
| yes | no | dk/u | Chipped or otherwise injured primary (baby) or permanent teeth? | yes | no | dk/u | Have you ever been treated for "TMD" or "TMJ" problems?                               |
| yes | no | dk/u | Teeth sensitive to hot or cold; teeth throb or ache?            | yes | no | dk/u | Aware of loose, broken or missing restorations (fillings)?                            |
| yes | no | dk/u | Jaw fractures, cysts or mouth infections?                       | yes | no | dk/u | Any teeth irritating check, lip, tongue or palate?                                    |
| yes | no | dk/u | "Dead teeth" or root canals treated?                            | yes | no | dk/u | Concerned about spaced, crooked or protruding teeth?                                  |
| yes | no | dk/u | Bleeding gums, bad taste or mouth odor?                         | yes | no | dk/u | Aware or concerned about under or over developed jaw?                                 |
| yes | no | dk/u | Periodontal "gum problems"?                                     | yes | no | dk/u | Any relative with similar tooth or jaw relationships?                                 |
| yes | no | dk/u | Food impaction between teeth?                                   | yes | no | dk/u | Any wisdom tooth problems?  |
| yes | no | dk/u | "Gum boils", frequent canker sores or cold sores?               | yes | no | dk/u | Had periodontal (gum) treatment?  |
| yes | no | dk/u | Thumb, finger, or sucking habit? Until what age _____?          | yes | no | dk/u | Had any serious trouble associated with any previous dental treatment?                |
| yes | no | dk/u | Abnormal swallowing habit (tongue thrusting)?                   | yes | no | dk/u | Been under another dentist's care?<br>Specialist _____<br>Other _____                 |
| yes | no | dk/u | History of speech problems?                                     | yes | no | dk/u | Ever had a prior orthodontic examination or treatment?                                |
| yes | no | dk/u | Mouth breathing habit, snoring or difficulty in breathing?      | yes | no | dk/u | Would you object to wearing orthodontic appliances (braces) should they be indicated? |
| 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?    |     |    |      |   |

How often do you brush: \_\_\_\_\_ floss: \_\_\_\_\_

What is your primary concern? Why are you here? \_\_\_\_\_

Questions: \_\_\_\_\_

## DOCTOR CONTACT INFORMATION

Doctor's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name/Initial: \_\_\_\_\_  
Office Phone No.: (\_\_\_\_) - \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Doctor's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

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)

**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)