# MEDICAL DENTAL HISTORY- ADULT

Patient's Name:_____ Age:_____ Birth Date:_____

□ Male □ Female Phone Number: _____ □ Single □ Married

Home Address: _____

Email :_____ How did you hear about us? _____

Who suggested that you might need orthodontic treatment? _____

Dentist: _____ Phone Number: _____

Date of Last Dental Exam:_____ Reason: _____

Is the patient allergic to latex? _____ History of antibiotic prophylaxis for dental treatment? _____

Please check each box, yes or no, if you have ever had any illness or conditions listed below.

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| □ | □ | Arthritis | □ | □ | Allergies | □ | □ | Anemia | □ | □ | Artificial Joint |
| □ | □ | Asthma | □ | □ | Cancer | □ | □ | Diabetes | □ | □ | Dizzy Spells |
| □ | □ | Epilepsy | □ | □ | Fainting | □ | □ | Heart Murmur | □ | □ | Hepatitis |
| □ | □ | Kidney Disease | □ | □ | Liver Problems | □ | □ | Lung Disease | □ | □ | Nervous Disorder |
| □ | □ | Mental Disorder | □ | □ | Sinus Trouble | □ | □ | Stroke | □ | □ | Tuberculosis |
| □ | □ | Tobacco | □ | □ | Hospitalization | □ | □ | Alcohol | □ | □ | Recreational Drugs |
| □ | □ | Supernumerary (extra) teeth | | | | □ | □ | Jaw fractures, cysts or mouth infections | | | |
| □ | □ | Periodontal "gum problems" | | | | □ | □ | Pain in jaw or ringing in ears | | | |
| □ | □ | Congenitally missing teeth | | | | □ | □ | Family history of jaw size imbalance | | | |

Have you had any disease, serious illness/surgery, condition or problem not listed above? Y N
If yes, explain_____

Are you currently taking medications, nutrient supplements, herbal medications or non-prescription medicines? Please name them. _____
_____

***To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my health. I further certify that I consent to the performing of x-rays, oral examination, and pictures taken for office records.***

_____ _____
Patient's Signature/Responsible Party Date

**For Doctor's Use Only**

Health History Reviewed By_____ (Dr Signature) Date:_____
Notes:
_____
_____
_____