

CERTIFIED SPECIALISTS
IN ORTHODONTICS

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ADULT MEDICAL HISTORY FORM UPDATED

FULL NAME _____ NAME YOU PREFER _____ DATE _____
BIRTHDATE: MONTH _____ DAY _____ YEAR _____ AGE _____ MARITAL STATUS _____
ADDRESS _____ CITY _____ P. CODE _____ PHONE _____
EMPLOYER _____ OCCUPATION _____
BUSINESS ADDRESS _____ BUS. TEL. _____
DENTIST _____ PHYSICIAN _____

PATIENT HEALTH HISTORY:

IS YOUR GENERAL HEALTH GOOD? _____ ANY MAJOR OR UNUSUAL ILLNESSES: _____

ANY ALLERGIC REACTIONS? _____ TAKING ANY MEDICATION? _____

HAVE YOU SEEN A PHYSICIAN IN THE PAST SIX MONTHS? _____

PLEASE CIRCLE IF YOU HAVE/HAD ANY OF THE FOLLOWING:

HEART PROBLEMS	ASTHMA	FAINING	HEPATITIS (LIVER DISEASE)
RHEUMATIC FEVER	TUBERCULOSIS	BLEEDING	KIDNEY DISEASE
DIABETES	CONVULSIONS	ALLERGIES	THYROID PROBLEMS
NERVOUS DISORDERS			

(WOMEN) ARE YOU PREGNANT NOW? _____

WHEN WAS YOUR LAST DENTAL EXAMINATION? _____

WERE THE NECESSARY FILLINGS AND A TOOTH CLEANING COMPLETED THEN? _____

DO YOU GRIND OR CLENCH YOUR TEETH? _____

DO YOU FREQUENTLY HAVE HEADACHES, TIRED OR SORE JAW MUSCLES? _____

DO YOU HAVE JAW PROBLEMS (PAIN, CLICKING, LOCKING, ETC.) IF SO, PLEASE DESCRIBE: _____

HAVE YOU EVER BEEN TOLD YOU HAVE PERIODONTAL OR GUM DISEASE? _____

IS THERE ANYTHING ELSE IN YOUR MEDICAL OR DENTAL HISTORY YOU FEEL WE SHOULD BE AWARE OF? _____

PLEASE DESCRIBE _____

SIGNATURE OF PATIENT: _____