

CERTIFIED SPECIALISTS  
IN ORTHODONTICS

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**ADULT MEDICAL HISTORY FORM**

FULL NAME \_\_\_\_\_ NAME YOU PREFER \_\_\_\_\_ DATE \_\_\_\_\_

BIRTHDATE: MONTH \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ P. CODE \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ BUS. TEL. \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ BUS. TEL. \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT \_\_\_\_\_ DO YOU HAVE ORTHODONTIC COVERAGE? \_\_\_\_\_

DENTIST \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

REFERRED BY \_\_\_\_\_

HAVE YOU EVER HAD ORTHODONTIC TREATMENT BEFORE? \_\_\_\_\_

ARE THERE OR HAVE THERE BEEN OTHER MEMBERS IN THE FAMILY UNDER ORTHODONTIC TREATMENT? \_\_\_\_\_

REASON(S) FOR SEEKING ORTHODONTIC TREATMENT? \_\_\_\_\_

ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR TEETH? \_\_\_\_\_

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? \_\_\_\_\_

**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** \_\_\_\_\_