

FAMILY ORTHODONTIC CARE, P.C.

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**Adult Health & History Form
(PLEASE PRINT & BRING WITH YOU TO APPOINTMENT)**

Date: ___/___/___

Patient's Last Name _____ First _____ MI _____

Address _____

Home Phone No _____ DOB ___/___/___ Age _____ Sex _____

Whom may we thank for referring you to our practice _____

In Case We Cannot Reach You-Person to contact _____ Phone _____

Name & Address of Family Dentist _____

Name & Address of Family Physician _____

Current Weight _____ Current Height _____

Current Medications _____

Have you ever been hospitalized? Yes / No (if yes, reason) _____

Do you have any allergies to medications? Yes/ No (if yes, explain) _____

Do you have a condition requiring antibiotic prophylaxis before dental procedures? Yes / No (if yes, explain) _____

For the following questions circle yes, no or don't know/understand (dk/u). This information is for office use only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Medical History

- Yes No dk/u Birth defects or hereditary problems?
- Yes No dk/u Bone fractures or major accidents?
- Yes No dk/u Rheumatoid or arthritic conditions?
- Yes No dk/u Endocrine or thyroid problem?
- Yes No dk/u Kidney problems?
- Yes No dk/u Diabetes?
- Yes No dk/u Cancer or been treated for a tumor?
- Yes No dk/u Stomach ulcer or hyperacidity?
- Yes No dk/u Polio, mono, tuberculosis, pneumonia?
- Yes No dk/u Problems with 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 problems?
- Yes No dk/u Mental Health or behavioral problems?
- Yes No dk/u Vision, hearing, tasting, or speech difficulties?
- Yes No dk/u Cardiovascular problems, rheumatic heart disease, heart murmur?
- Yes No dk/u Do you currently or ever had a substance abuse problem?
- Yes No dk/u Other physical problem or symptom? _____
- Yes No dk/u Being treated by another health care professional? For _____
- Yes No dk/u Date of last physical exam _____

Female Patients

- Yes No dk/u Are you pregnant?
- Yes No dk/u Are you taking birth control pills?
- Yes No dk/u Do you anticipate becoming pregnant?

Dental History

- Yes No dk/u Permanent or "extra" teeth removed?
- Yes No dk/u Supernumerary (extra) or congenitally missing teeth?
- Yes No dk/u Chipped or otherwise injured permanent teeth?
- Yes No dk/u Teeth sensitive to hot or cold; teeth throb or ache?
- Yes No dk/u Jaw fractures, cysts or mouth infections?
- Yes No dk/u "Dead teeth" or root canal treatment?
- Yes No dk/u Bleeding gums, bad taste, mouth odor?
- Yes No dk/u Periodontal "Gum problems"?
- Yes No dk/u Food impaction between teeth?
- Yes No dk/u "Gum boils", frequent canker sores, cold sores?
- Yes No dk/u Thumb finger sucking habit? Until _____
- Yes No dk/u Abnormal-swallowing habit (tongue thrusting) ?
- Yes No dk/u History of speech problem?
- Yes No dk/u Mouth breathing habit, snoring, difficulty in breathing?
- Yes No dk/u Tooth grinding, jaw clenching, clicking, locking?
- Yes No dk/u Any pain in jaws or ringing in ears?
- Yes No dk/u Any pain or soreness in muscles of the face, or around the ears?
- Yes No dk/u Difficulty in chewing or jaw opening?
- Yes No dk/u Aware of loose, broken or missing restorations (fillings)?
- Yes No dk/u Any teeth irritating cheek, lip, tongue, palate?
- Yes No dk/u Concerned about spaced, crooked, protruding teeth?
- Yes No dk/u Aware or concerned about under or over developed jaw?
- Yes No dk/u Any relative with similar tooth or jaw relationships?
- Yes No dk/u Any "wisdom tooth" problems?
- Yes No dk/u Have you ever had a prior orthodontic examination or treatment?

Date of last dental visit _____ Any radiographs taken? _____

What would you like to gain by orthodontic treatment?

- Eliminate dental crowding
- Treat overbite
- Treat underbite
- Correct my profile
- Move teeth so that bridges or implants can be made
- Easier cleaning teeth
- A nice smile
- Other _____

I have answered these questions truthfully, and to the best of my knowledge. If there are any changes in my health/history information I will inform this practice.

Signature _____ Date _____