ADULT DENTAL/MEDICAL HEALTH HISTORY

Craig & Streight
ORTHODONTICS
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Patient's Name: _____ Date: _____
(first) (middle) (last)

DENTAL

YES	NO	
☐	☐	Have you ever experienced any unfavorable reaction to dentistry?
☐	☐	Have you ever knocked out or chipped any teeth?
☐	☐	Have you ever been informed of extra or missing teeth?
☐	☐	Is any part of your mouth sensitive to temperature or pressure?
☐	☐	Do you brush your teeth daily?
☐	☐	Do you floss regularly?
☐	☐	Do your gums bleed when you brush?
☐	☐	Do you predominantly breathe through your mouth?
☐	☐	Do you require pre-medication for dental procedures?
☐	☐	Do you have any kind of finger/thumb or tongue habit?
☐	☐	Have you ever had any pain/tenderness in your jaw (TMJ/TMD)?
☐	☐	Are you aware of jaw clicking or popping?
☐	☐	Do you clench or grind your teeth?
☐	☐	Have you ever experienced chronic ringing in your ears?
☐	☐	Do you have "tension" headaches?
☐	☐	Do you have difficulty chewing or swallowing food?
☐	☐	Have you ever had to take antibiotics prior to a dental visit / checkup?
☐	☐	Smoking or tobacco use?

What is your primary concern with your teeth? _____

_____

Has your dentist pointed to some orthodontic problem? _____

Have you previously consulted an orthodontist? _____

Have you had any previous orthodontic treatment? _____

Date of your most recent dental examination: _____

Are you aware of any dental work that needs to be completed prior to orthodontic treatment? _____

_____

Have there been any injuries to your face, mouth, teeth or chin? If yes, please explain:

_____

Have any teeth been removed by extraction? If yes, please explain: _____

_____

Has anyone else in your family received orthodontic treatment? If yes, how did they feel about the results? _____

_____

MEDICAL

Have you ever had any of the following diseases/medical conditions?

YES	NO	
☐	☐	Abnormal Bleeding / Hemophilia
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asthma / Hayfever
☐	☐	Birth Defects
☐	☐	Blood Disorders
☐	☐	Bone Disorders
☐	☐	Congenital Heart Defect
☐	☐	Depression / Mental Illness
☐	☐	Diabetes
☐	☐	Dizziness
☐	☐	Endocrine Problems
☐	☐	Epilepsy
☐	☐	Gastrointestinal Disorders
☐	☐	Heart Problems
☐	☐	Heart Murmur
☐	☐	Hepatitis / Liver Problems
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	HIV+ / AIDS
☐	☐	Kidney Problems
☐	☐	Nervous Disorders
☐	☐	Osteoporosis
☐	☐	Pneumonia
☐	☐	Prolonged Bleeding
☐	☐	Radiation / Chemotherapy
☐	☐	Rheumatic Fever
☐	☐	Tuberculosis
☐	☐	Tumor / Cancer
☐	☐	Joint Replacement
☐	☐	Have you ever taken or are you now taking bisphosphonate medication?
☐	☐	Other: _____

(continued . . .)

FEMALE PATIENTS:

YES	NO	
☐	☐	Are you pregnant? Week # _____
☐	☐	Are you taking birth control pills?
☐	☐	Are you anticipating becoming pregnant?

(continued . . .)

Have you experienced allergic reactions to any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Tetracycline
☐	☐	Codeine	☐	☐	Latex	☐	☐	Metals:_____
☐	☐	Dental Anesthetics	☐	☐	Penicillin	☐	☐	Other:

Please list all medications that you are currently taking: _____

_____

Are you currently under the care of a physician? If yes, please explain: _____

_____

_____

_____

Please explain any medical problems that you have had in the past: _____

_____

I have read and I understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical / dental status.

We may discuss your treatment with referring doctor / dentist for the furtherment of your treatment.

I understand that if I choose to proceed with recommended treatment, the next step includes diagnostic records. There will be a fee for diagnostic records. I consent to the taking of photographs, models and x-rays for diagnostic purposes.

_____

Signature of patient Date

MEDICAL HISTORY UPDATES OR CHANGES

Date:_____	Date:_____	Date:_____
Comments:_____	Comments:_____	Comments:_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Signature:_____	Signature:_____	Signature:_____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions, please do not hesitate to ask us. We are always happy to help.