

Medical/Dental History - Adult and Child

Patient's Name: _____ Date: _____

D E N T A L H I S T O R Y

Patient's Dentist _____ Date of Last Visit _____

1. Have there been any injuries to the face, mouth or teeth? YES NO
2. Have you had or do you presently have any of the following habits?
 NO Thumb or finger sucking Lip Biting Snoring
 Grinding of teeth at night Mouth breathing
3. Have you been informed of any missing or extra permanent teeth? YES NO
4. Are you aware of sores or irritated areas in the mouth? YES NO
5. Have you had orthodontic treatment in the past? YES NO
Name: _____ Date: _____
6. Have you ever been treated for:
If so, by whom? NO Bad Bite TMJ Periodontal Disease
7. Do you have any speech problems? YES NO
8. Are you frightened or anxious about Orthodontic treatment? YES NO
9. Are you concerned about the appearance of your teeth? YES NO
10. Is there anything you would like to change about your smile?
If so, what: YES NO
11. What aspect of dental treatment are you most concerned with? Quality Cost Discomfort Time
12. Reason for consultation (chief concern): _____
13. Has there ever been any orthodontic treatment for any other member of your family? YES NO Stage of TX: _____
Were they satisfied with the results? YES NO
Sons (Dr. _____) Daughters (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)

M E D I C A L H I S T O R Y

1. Is your general health good at this time? YES NO
2. Are you under the care of your family physician? YES NO
Explain: _____
3. What is the name of your family physician? _____ Date of last physical: _____
4. Please name all medications you are currently taking
Name: _____
5. Are you allergic to any medication (Penicillin, Sulfa, etc.)? YES NO
Name: _____
6. Have you ever taken any diet medication (Fen-Phen)? YES NO
7. Have you ever had a serious illness or been hospitalized? YES NO
8. Have you had your tonsils and/or adenoids removed? YES NO
9. Do you have any history of mental illness? YES NO
Explain: _____
10. Are you taking medication for anxiety or depression? YES NO
11. Do you have any heart defects, such as mitral valve prolapse, heart murmur or any joint replacement that requires you to premedicate before dental appointments? YES NO
If yes, antibiotic name and method _____ Pharmacy: _____
12. Do you use tobacco? (smoking or chewing) YES NO
13. What is your approximate height? _____ Weight? _____
14. **WOMEN:**
Are you pregnant or considering pregnancy during the next 2 years? YES NO Are you nursing? YES NO
Are you currently taking medication for birth control? YES NO