Adult Health History

NAME:	YOUR OCCUPATION:
ADDRESS:	BUS. ADDRESS:
CITY: ZIP:	BUS. PHONE: BUS. FAX: BUS. E-MAIL:
PHONE #: FAX: E-MAIL:	CELL PHONE:
D.O.B.: AGE: MALE/FEMALE ☐ ☐	SPOUSE'S NAME: SPOUSE'S OCCUPATION:
MARITAL STATUS:	BUS. ADDRESS:
PARTY RESPONSIBLE FOR ACCT.:	BUS. PHONE: BUS. FAX: BUS. E-MAIL:
REFERRED TO THIS OFFICE BY:	CELL PHONE:
WHAT IS YOUR REASON FOR SEEKING AN ORTHODONTIC EVALUATION?	
SPECIAL MEDICAL ALERT - ***For office use only***	

PERSONAL INFORMATION

1. Do you have any special hobbies or interests? ❒ Yes ❒ No
   Please describe: _____
2. Do you have any children? (list names, ages, and sex) _____

DENTAL

DENTIST'S NAME: _____

ADDRESS: _____ **PHONE:** _____

Have you:

1. A fear of dentists? ❒ Yes ❒ No
2. Noticed yourself clenching or grinding your teeth? ❒ Yes ❒ No
3. Ever had pain when opening or closing your mouth? ❒ Yes ❒ No
4. Trouble with bad breath or bad taste in your mouth? ❒ Yes ❒ No
5. A history of "Cold sores" or acutely sore mouth? ❒ Yes ❒ No
6. A history of soreness of jaw muscle or jaw joint? ❒ Yes ❒ No
7. A history of previous orthodontic therapy? ❒ Yes ❒ No
8. Had traumatic injury to the head or face? ❒ Yes ❒ No

Are you experiencing:

9. Discomfort with your teeth? ❒ Yes ❒ No
10. Sensitivity to hot/cold? ❒ Yes ❒ No
11. Bleeding gums/sore gums? ❒ Yes ❒ No
12. Bite shifting/looseness? ❒ Yes ❒ No
13. Self-conscious about certain facial features? ❒ Yes ❒ No
14. Self-conscious about the appearance of your teeth? ❒ Yes ❒ No
15. Any discomfort or unusual changes in the soft tissue of the mouth? ❒ Yes ❒ No

If yes was answered to any of the above, please explain: _____

MEDICAL

PHYSICIAN'S NAME: _____

ADDRESS: _____ **PHONE:** _____

Are you:

1. Under physicians care? ❒ Yes ❒ No
2. Taking medication? ❒ Yes ❒ No

Do you have any history of:

3. Hospitalizations? ❒ Yes ❒ No
4. Rheumatic Fever, Heart Disease, or Heart Murmur? ❒ Yes ❒ No
5. Respiratory problems? ❒ Yes ❒ No
6. Mouth breathing? ❒ Yes ❒ No
7. Prolonged bleeding? ❒ Yes ❒ No
8. Diabetes? ❒ Yes ❒ No
9. Joints often painful or swollen? ❒ Yes ❒ No
10. Anemia? ❒ Yes ❒ No
11. Epilepsy? ❒ Yes ❒ No
12. Thyroid or Hormone Therapy? ❒ Yes ❒ No
13. Severe headaches? ❒ Yes ❒ No
14. Pains of face or head? ❒ Yes ❒ No
15. Tumors or Cancer? ❒ Yes ❒ No
16. Syphilis or Gonorrhea? ❒ Yes ❒ No
17. Receiving x-ray or radioactive isotope treatment? ❒ Yes ❒ No
18. Yellow jaundice or Hepatitis, AIDS, Herpes or other immuno-suppressive disorders? ❒ Yes ❒ No
19. Allergies (i.e., aspirin, penicillin, Novocain, etc.)? ❒ Yes ❒ No

    _____

20. Are there any special medical conditions of which we should be aware? ❒ Yes ❒ No
    Please describe : _____

If yes was answered to any of the above, please explain: _____

WOMEN

1. Are you pregnant now? ❒ Yes ❒ No
2. Are you taking birth control pills? ❒ Yes ❒ No

OTHER

1. Do you take multiple vitamins? ❒ Yes ❒ No
2. Do you smoke more than two packages of cigarettes per week? ❒ Yes ❒ No

I give permission to release any pertinent information to any involved insurance companies or medical/dental professionals.
To the best of my knowledge, the above statements are true and accurate. I agree to inform this office of any changes in the status of my health.

Signature: _____ *Date:* _____