American Association of
Orthodontists

Date: ___________

CONFIDENTIAL

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM – ADULT

Patient's Last Name: ____________ First Name: ____________ Middle Name/Initial: ________

Birth Date: ____________ Age: ______ Sex: Male ❑ Female ❑ I Prefer To Be Called: ____________

S.S.N./S.I.N.: ____________ Home Phone No.: ____________ E-mail address: ____________

Cell phone number: ____________ Pager number: ____________

Patient's Address: ____________

City: ____________ State/Province: ____________ Zip/Postal Code: ____________

Years at above address: ____________

If less than 5 years at current address, previous address: ____________

Years at previous address: ________ Patient is: Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑

Occupation: ____________ Employer: ____________ Years with Employer: ________

Business Phone No.: ____________

Name Of Spouse/Closest Relative: ____________ Phone No.: (if different than yours) ____________

Relationship To You: ____________

Address (if different than yours): ____________

City: ____________ State/Province: ____________ Zip/Postal Code: ____________

Name Of Patient's Dentist: ____________

Phone No.: ____________

Dentist's Address: ____________

City: ____________ State/Province: ____________ Zip/Postal Code: ____________

Date Last Seen: ________ Reason: ____________

Name Of Patient's Physician(s): ____________

Phone No(s).: ____________

Physician's Address: ____________

City: ____________ State/Province: ____________ Zip/Postal Code: ____________

Date Last Seen: ________ Reason: ____________

Who suggested that you might need orthodontic treatment? ____________

Why did you select our office? ____________

Who Is Financially Responsible For This Account?

Last Name: ____________ First Name: ____________ Middle Name/Initial: ________

Address (if different than patient's) ____________

Phone No.: ____________

City: ____________ State/Province: ____________ Zip/Postal Code: ____________

WOMEN ONLY

❑ yes ❑ no ❑ dk/u Are you pregnant?
❑ yes ❑ no ❑ dk/u Are you anticipating becoming pregnant?

FAMILY MEDICAL HISTORY

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain.

Bleeding disorders ______________________________

Diabetes ______________________________

Arthritis ______________________________

Severe allergies ______________________________

Unusual dental problems ______________________________

Jaw size imbalance ______________________________

Any other family medical conditions that we should know about?

____

DENTAL HISTORY

Now or in the past, have you had:

❑ yes ❑ no ❑ dk/u Permanent or "extra" (supernumerary) teeth removed?
❑ yes ❑ no ❑ dk/u Supernumerary (extra) or congenitally missing teeth?
❑ yes ❑ no ❑ dk/u Chipped or otherwise injured primary (baby) or 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 canals treated?
❑ yes ❑ no ❑ dk/u Bleeding gums, bad taste or 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 or cold sores?
❑ yes ❑ no ❑ dk/u Thumb, finger, or sucking habit? Until what age______?
❑ yes ❑ no ❑ dk/u Abnormal swallowing habit (tongue thrusting)?
❑ yes ❑ no ❑ dk/u History of speech problems?
❑ yes ❑ no ❑ dk/u Mouth breathing habit, snoring or difficulty in breathing?
❑ yes ❑ no ❑ dk/u Tooth grinding or jaw clenching?
❑ yes ❑ no ❑ dk/u Any pain, clicking or locking in jaw or ringing in the ears?
❑ yes ❑ no ❑ dk/u Any pain or soreness in the muscles of the face or around the ears?
❑ yes ❑ no ❑ dk/u Difficulty in chewing or jaw opening?
❑ yes ❑ no ❑ dk/u Have you ever been treated for "TMD" or "TMJ" problems?
❑ yes ❑ no ❑ dk/u Aware of loose, broken or missing restorations (fillings)?
❑ yes ❑ no ❑ dk/u Any teeth irritating cheek, lip, tongue or palate?
❑ yes ❑ no ❑ dk/u Concerned about spaced, crooked or 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 Had periodontal (gum) treatment?
❑ yes ❑ no ❑ dk/u Had any serious trouble associated with any previous dental treatment?
❑ yes ❑ no ❑ dk/u Been under another dentist's care?

Specialist ______________________________

Other ______________________________

❑ yes ❑ no ❑ dk/u Ever had a prior orthodontic examination or treatment?
❑ yes ❑ no ❑ dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: ______________ Floss: ______________

What is your primary concern? Why are you here? ______________________________

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: ______________________________ Date Signed: ______________
(Patient)

Signed: ______________________________ Date Signed: ______________
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ______________________________

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Signed: ______________________________ Date Signed: ______________
(Patient)

Signed: ______________________________ Date Signed: ______________
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

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MEDICAL HISTORY UPDATE OR CHANGES

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