CONFIDENTIAL

Date:_____

Members American Association of Orthodontists

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM - ADULT

Patient's First Name: _____ Middle: _____ Last: _____

Birthdate: _____Age:_____ Sex: ☐ Male ☐ Female

Patient is ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Present Weight: _____lbs. Height: ____ft. ____ in. Musical Instrument Played:_____

Favorite Sports, Hobbies & Avocations: _____

Name of Dentist:_____

For the following questions mark **yes, no, or don't know/understand(dk/u).** The answers are for office records 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, any major accidents?
☐ **yes** ☐ **no** ☐ **dk/u** Rheumatoid or arthritic conditions
☐ **yes** ☐ **no** ☐ **dk/u** Endocrine or thyroid problems?
☐ **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, mononucleosis, tuberculosis, pneumonia?
☐ **yes** ☐ **no** ☐ **dk/u** Problems of the immune system?
☐ **yes** ☐ **no** ☐ **dk/u** Hepatitis, jaundice or liver problem?
☐ **yes** ☐ **no** ☐ **dk/u** AIDS or HIV Positive?
☐ **yes** ☐ **no** ☐ **dk/u** Sexually transmitted disease?
☐ **yes** ☐ **no** ☐ **dk/u** Fainting spells, seizures, epilepsy or neurologic disease?
☐ **yes** ☐ **no** ☐ **dk/u** Mental health or behavioral problems
☐ **yes** ☐ **no** ☐ **dk/u** Vision, hearing, tasting or speech difficulties?
☐ **yes** ☐ **no** ☐ **dk/u** Loss of weight recently, poor appetite?
☐ **yes** ☐ **no** ☐ **dk/u** Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
☐ **yes** ☐ **no** ☐ **dk/u** High or low blood pressure?
☐ **yes** ☐ **no** ☐ **dk/u** Easily tired?
☐ **yes** ☐ **no** ☐ **dk/u** Chest pain, shortness of breath or swelling ankles?
☐ **yes** ☐ **no** ☐ **dk/u** Skin disorder?
☐ **yes** ☐ **no** ☐ **dk/u** Do you have a normal and good diet?

☐ **yes** ☐ **no** ☐ **dk/u** Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
☐ **yes** ☐ **no** ☐ **dk/u** Frequent headaches, colds or sore throats?
☐ **yes** ☐ **no** ☐ **dk/u** Any history of speech problems?
☐ **yes** ☐ **no** ☐ **dk/u** Eye, ear, nose, throat condition?
☐ **yes** ☐ **no** ☐ **dk/u** Hayfever, asthma, sinus trouble, hives?
☐ **yes** ☐ **no** ☐ **dk/u** Tonsil or adenoid conditions?
☐ **yes** ☐ **no** ☐ **dk/u** Allergies or drug reactions?
Describe: _____
☐ **yes** ☐ **no** ☐ **dk/u** Are you taking medication, nutrient supplements or non prescription medicine? Please name them:
_____
☐ **yes** ☐ **no** ☐ **dk/u** Do you currently have or ever had a substance abuse problem?
☐ **yes** ☐ **no** ☐ **dk/u** Operations?
Describe: _____
☐ **yes** ☐ **no** ☐ **dk/u** Hospitalized?
Describe: _____
☐ **yes** ☐ **no** ☐ **dk/u** Other physical problems or symptoms?
Describe: _____
☐ **yes** ☐ **no** ☐ **dk/u** Being treated by another health care professional?
Describe: _____
☐ **yes** ☐ **no** ☐ **dk/u** Are you in good health?
Date of most recent physical exam? _____

FEMALE PATIENT

☐ **yes** ☐ **no** ☐ **dk/u** Are you pregnant?
☐ **yes** ☐ **no** ☐ **dk/u** Are you taking birth control pills?
☐ **yes** ☐ **no** ☐ **dk/u** Are you anticipating becoming pregnant?

Over >

DENTAL HISTORY

☐ **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, mouth infections?

☐ **yes** ☐ **no** ☐ **dk/u** Thumb, finger sucking habit?
Until: _____

☐ **yes** ☐ **no** ☐ **dk/u** Abnormal swallowing habit (tongue thrusting)?

☐ **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** Do you experience any pain or soreness in the muscles of your face, or around the ears?

☐ **yes** ☐ **no** ☐ **dk/u** Any pain in jaw or ringing in the ears?

☐ **yes** ☐ **no** ☐ **dk/u** Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)

☐ **yes** ☐ **no** ☐ **dk/u** Difficulty encountered in chewing or jaw opening?

☐ **yes** ☐ **no** ☐ **dk/u** History of supernumerary (extra) or congenitally missing teeth?

☐ **yes** ☐ **no** ☐ **dk/u** Have any permanent teeth been removed?

☐ **yes** ☐ **no** ☐ **dk/u** Aware of loose, broken or missing restorations (fillings)?

☐ **yes** ☐ **no** ☐ **dk/u** "Dead Teeth", root canals treated?

☐ **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** Any teeth irritating cheek, lip, tongue, palate?

☐ **yes** ☐ **no** ☐ **dk/u** Have you ever had orthodontic treatment or worn a "retainer" or "bite plate"?

☐ **yes** ☐ **no** ☐ **dk/u** Have you recently been under another dentist's care?
Specialist:_____

☐ **yes** ☐ **no** ☐ **dk/u** Have you ever had periodontal (gum) treatment?

☐ **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 had any serious trouble associated with any previous dental treatment?

What is your primary concern? _____Why are you here? _____

Date of most recent dental examination? _____How often do you brush: _____Floss: _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____

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 by Patient: **Date Signed:**

Comments: _____

_____

_____

_____

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *dose off* or *fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3: with 0 meaning you would never *doze* or *fall asleep* in a given situation; and 3 meaning that there is a very high chance that you would *doze* or *fall asleep* in that situation.

How likely are you to *doze off* or *fall asleep* in the following situations, in contrast to just feeling tired: Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

It is important that you select a number (0 to 3) for EACH situation.

SITUATION	**CHANCE OF DOZING** 0	1	2	3
Sitting and Reading	☐	☐	☐	☐
Watching Television	☐	☐	☐	☐
Sitting Inactive in a public place (theater/meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch (with no alcohol)	☐	☐	☐	☐
In a car, while stopped in traffic	☐	☐	☐	☐

TOTAL SCORE _____

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Please Select Y for Yes or N for No:

☐ Y ☐ N Have you ever had clicking or popping from your jaw joints?

☐ Y ☐ N Do you have pain around your ears or face?

☐ Y ☐ N Has your bite changed over the last five years?

☐ Y ☐ N Can you open wide enough to place three fingers vertically in your mouth?

☐ Y ☐ N Has your jaw ever locked in an open or closed position?

☐ Y ☐ N Do you clench or grind your teeth?

Date_____ **Confidential Responsible Party Information** A B C

Name_____ Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____ Email_____
Street City State Zip

How long at this address_____ Previous Address_____
(if less than 3 yrs) Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Confidential Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office?_____

Insurance Information

Policy Holder's Name_____ and Soc.Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Do you have dual coverage? No ☐ Yes ☐ If yes: _____

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parent's signature if minor)_____

Updates (date & initial)_____

CONFIDENTIAL (for record and pretreatment evaluation)