Adult Health History

Patient's Name:_____

Date:_____ Birthdate_____

Wood Orthodontics

CREATING SMILES FOR A LIFETIME

Dental History

Y	N	
☐	☐	Have you ever had a bad dental experience?
☐	☐	Have you ever knocked out or chipped any teeth?
☐	☐	Have you ever been informed of extra or missing teeth?
☐	☐	Is 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 antibiotic premedication?
☐	☐	Do you smoke or use tobacco products in any form?
☐	☐	Do you experience pain or tenderness in your jaw?
☐	☐	Do you have popping/clicking in your jaw?
☐	☐	Do you clench or grind your teeth?
☐	☐	Have you experienced chronic ringing in your ears?
☐	☐	Do you have "tension" headaches?
☐	☐	Do you have any difficulty chewing/swallowing food?
☐	☐	Does your bite feel uncomfortable?

What is your primary concern with your teeth?

_____

_____

Has an orthodontist previously been consulted? _____

If yes, whom? _____

_____

Is there any dental work you are aware of that needs completion before orthodontic treatment? _____

Approximate date of most recent dental exam: _____

Have you had any injuries to your face, mouth, teeth or chin?_____

If yes, please explain:_____

_____

Has anyone else in your family had orthodontic treatment?_____

If yes, how do they feel about the results?_____

Medical History

Y	N	
☐	☐	Abnormal Bleeding/Hemophilia
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asthma/Hay fever
☐	☐	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
☐	☐	Pneumonia
☐	☐	Prolonged Bleeding
☐	☐	Radiation/Chemotherapy
☐	☐	Rheumatic Fever
☐	☐	Tuberculosis
☐	☐	Tumor/Cancer
☐	☐	Other:_____

_____

Female Patients:

Y	N	
□	□	Are you Pregnant? Week#_____
□	□	Are you taking birth control?
□	□	Are you anticipating becoming pregnant?

Have you ever had an allergic reaction to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Tetracycline
☐	☐	Codeine	☐	☐	Latex	☐	☐	Metals:_____
☐	☐	Dental Anesthetics	☐	☐	Penicillin	☐	☐	Others:_____

Have you ever had to take antibiotics prior to a dental visit or checkup? _____

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 conditions 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.

I understand my treatment may be discussed with the person(s) financially responsible for my treatment / referring doctor / dentist for the furtherment of my treatment.

_____

Signature of patient Date

Medical History Updates or Changes

Date: _____ Date: _____

Comments: _____ Comments: _____

_____ _____

_____ _____

_____ _____

Signature: _____ Signature: _____

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