TODAY'S DATE: _____ ***Welcome to our office!***

Mary Lynn Crews, D.M.D, P.C.

Orthodontic Patient Information

Patient (only) Information

Patient's Name_____ **Age**____ **Birthdate**_____ **Sex**____

Home Address_____ **City**_____ **Zip**_____

**** Please circle preferred contact number - it will be used for computer generated appointment reminder calls ****

Home Phone_____ **Work Phone (if applicable)**_____ **Cell Phone**_____

Patient's Employer/School_____ **Nickname/Preferred Name**_____

Patient's E-mail Address_____

Marital Status_____ **Patient living with** *(please circle)*: Both Parents Mother Father Spouse Self Other_____

Who is Responsible for Patient Financially?_____

Responsible Parties

Name	_____	_____
Relationship to Patient *(please circle)*	Father Mother Other_____	Father Mother Other_____
Address	_____	_____
City, State	_____	_____
Phone (Home)	_____	_____
(Work)	_____	_____
(Cell)	_____	_____
E-mail Address	_____	_____
Place of Employment	_____	_____
Occupation	_____	_____

Medical Contacts / Referrals

	Family Dentist	**Referred By**
Name	_____	_____
City, State	_____	_____

Family History (if adolescent)

Sibling(s) (Name & Age)_____

Has any other family member previously been a patient at this office? (Name)_____

Biological Parents: (1)_____Living? Y N (2)_____Living? Y N

Is patient adopted? Y N If so, does patient know? Y N Also, do you know any genetic history of biological parents? Y N

Family History (if adult)

Children (Name & Age)_____

Has any other family member previously been a patient at this office? (Name)_____

Are you adopted? Y N Do you know any genetic history of biological parents? Y N

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM - ADULT

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

Now or in the past, have you had:

☐ 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, tumor, radiation treatment or chemotherapy?
☐ 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 AIDS, AIDS Rel complex or HIV positive?
☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or liver problems?
☐ yes ☐ no ☐ dk/u Fainting/dizzy spells, seizures, epilepsy, convulsions or neurological problem?
☐ yes ☐ no ☐ dk/u Nervous conditions?
☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?
☐ yes ☐ no ☐ dk/u Vision, hearing, tasting or speech difficulties?
☐ yes ☐ no ☐ dk/u Loss of weight recently, poor appetite?
☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?
☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐ yes ☐ no ☐ dk/u High or low blood pressure?
☐ yes ☐ no ☐ dk/u Tired easily?
☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath or swelling ankles?
☐ yes ☐ no ☐ dk/u Cardiovascular problem (heart trouble, MVP, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic hear disease)?
☐ yes ☐ no ☐ dk/u Skin disorder?
☐ yes ☐ no ☐ dk/u Do you have a well-balanced diet?
☐ yes ☐ no ☐ dk/u Frequent headaches, colds or sore throats?
☐ yes ☐ no ☐ dk/u Eye, ear, nose or throat condition?
☐ yes ☐ no ☐ dk/u Hayfever, asthma, sinus trouble or hives?
☐ yes ☐ no ☐ dk/u Tonsil or adenoid conditions?
☐ yes ☐ no ☐ dk/u Osteoporosis?

Allergies or reactions to any of the following:

☐ yes ☐ no ☐ dk/u Local anesthetics (Novocaine or Lidocaine)
☐ yes ☐ no ☐ dk/u Aspirin
☐ yes ☐ no ☐ dk/u Ibuprofen (Motrin, Advil)
☐ yes ☐ no ☐ dk/u Penicillin or other antibiotics
☐ yes ☐ no ☐ dk/u Sulfa drugs
☐ yes ☐ no ☐ dk/u Codeine or other narcotics
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps) or **Nickel**
☐ yes ☐ no ☐ dk/u **Latex (gloves, balloons)**
☐ yes ☐ no ☐ dk/u Vinyl
☐ yes ☐ no ☐ dk/u Acrylic

☐ yes ☐ no ☐ dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

☐ yes ☐ no ☐ dk/u **Do you require antibiotic premedication for teeth cleaning or for other dental procedures?**
☐ yes ☐ no ☐ dk/u Do you currently have or ever had a substance abuse problem?
☐ yes ☐ no ☐ dk/u Do you chew or smoke tobacco?
☐ yes ☐ no ☐ dk/u Any serious Illness or Operations? Describe :
_____
☐ yes ☐ no ☐ dk/u Hospitalized? For: _____
☐ yes ☐ no ☐ dk/u Other physical problems or symptoms? Describe:
_____
☐ yes ☐ no ☐ dk/u Ever received medical treatment from allergist or ear, nose and throat specialist?
☐ yes ☐ no ☐ dk/u Being treated by another health care professional?
For: _____
Date of most recent physical exam? _____

Do you have any other medical conditions that we should know about?
_____

WOMEN ONLY

☐ yes ☐ no ☐ dk/u Are you pregnant?
☐ yes ☐ no ☐ dk/u Are you anticipating becoming pregnant?
☐ yes ☐ no ☐ dk/u Have you ever been treated for osteoporosis?
☐ yes ☐ no ☐ dk/u Have you ever taken Fosomax, Actonel, Boniva, or Reclast?

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 Nail chewing habit?

☐ 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 Do you wear a nightguard or a biteguard?

☐ 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, neck 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 (filings)?

☐ 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 Dry mouth?

☐ yes ☐ no ☐ dk/u Sore tongue?

☐ yes ☐ no ☐ dk/u Frequent cough or chronic cough?

☐ yes ☐ no ☐ dk/u Stuffy nose?

☐ yes ☐ no ☐ dk/u Frequent sore throats?

☐ yes ☐ no ☐ dk/u Frequent swollen tonsils?

☐ 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?
When? _____
By whom? _____
Are you seeking a 2nd opinion? _____

☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic treatment?
When? _____
Doctor: _____
Duration of Treatment: _____

☐ yes ☐ no ☐ dk/u Do you currently wear retainers? How often?_____

☐ 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? _____

What do you expect from orthodontic treatment? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of 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)