# Adult Orthodontic Medical History

PATIENT Dr. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑

NAME: ______________________

BIRTHDAY: ______________________

AGE: ______________________

ADDRESS: ______________________

(STREET)

______________________

(CITY) (POSTAL CODE)

RESIDENCE TEL: ______________________

BUSINESS TEL: ______________________

CELLULAR: EMAIL: ______________________

REFERRED BY: ______________________

DENTIST'S NAME: ______________________

DENTAL INSURANCE: Yes ❑ No ❑

1. WHAT ORTHODONTIC CONCERNS DO YOU HAVE ABOUT YOUR TEETH OR MOUTH?

   (Please specify.) ______________________

2. HAVE YOU OR ANY OTHER MEMBER OF YOUR FAMILY EXPERIENCED ORTHODONTIC TREATMENT? Yes ❑ No ❑

   (If yes, who?) ______________________

3. HAVE YOU SUFFERED ANY SEVERE ACCIDENTS INVOLVING: Face ❑ Teeth ❑ Jaws ❑ None ❑
4. DO YOU HAVE ALLERGIES RELATED TO: Asthma ❑ Hayfever ❑ Drugs ❑ Latex ❑ None ❑
5. DO YOU HAVE DIFFICULTY BREATHING THROUGH YOUR NOSE? Yes ❑ No ❑
6. DO YOU HAVE OR DID YOU EVER HAVE ANY ORAL HABITS SUCH AS: Thumb-sucking ❑ Finger-sucking ❑ Tongue-thrusting ❑ None ❑

   Other ❑ (please list.) ______________________

7. HAVE YOUR TONSILS AND/OR ADENOIDS BEEN REMOVED? Yes ❑ No ❑ (If so, when?) ______________________
8. HAVE YOU EXPERIENCED ANY COMPLEX OR UNUSUAL DENTAL TREATMENT? Yes ❑ No ❑

   (If so, please explain.) ______________________

9. ARE YOU PRESENTLY IN GOOD GENERAL HEALTH? Yes ❑ No ❑ PHYSICIAN'S NAME: ______________________
10. ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE FOR ANYTHING THAT IS OTHER THAN ROUTINE? Yes ❑ No ❑

    (If so, for what reason?) ______________________

11. ARE YOU CURRENTLY TAKING ANY MEDICATION? Yes ❑ No ❑

    (If so, please list.) ______________________

12. HAVE YOU EVER BEEN ADMITTED TO A HOSPITAL? Yes ❑ No ❑

    (If so, for what reason?) ______________________

13. HAVE YOU EVER EXPERIENCED ANY SERIOUS ILLNESSES SUCH AS: Rheumatic Fever ❑ Auto Immune Disease ❑ Hepatitis ❑

    Vascular Disorders ❑ Artificial Joints, Heart Valves, etc. ❑ Heart Disease ❑ None ❑

    Other ❑ (please list.) ______________________

14. HAVE YOU EXPERIENCED, CLICKING OF THE JAW, PAIN OR DIFFICULT CHEWING? Yes ❑ No ❑ (If so, when?) ______________________

______________________ *Signature*

______________________ *Date*

Our office complies with privacy legislation, the regulations of the Royal College of Dental Surgeons of Ontario and the law . Please be assured that every team member in our office is committed to protecting your personal health information.

The above medical history is correct to the best of my knowledge. I authorize my Doctor to consult with and/or send reports to medical and/or dental practitioners as it relates to orthodontic treatment.