



Patient's Name Birth Date

Address

Phone

ADULT CONFIDENTIAL MEDICAL HISTORY

I. PLEASE CIRCLE THE APPROPRIATE ANSWER. (Leave blank if you do not understand the question)

1 Yes No Do you have any health issues? If Yes, explain.

2 Yes No Has there been a change in your health within the last year? If Yes, explain.

3 Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years? If Yes, explain.

4 Yes No Are you being treated by a physician now? If Yes, explain.

Date of last medical exam Reason for exam

5 Yes No Have you had problems with prior dental treatment? If Yes, explain.

Date of last dental exam Name of previous dentist

6 Yes No Have there been any injuries to the face, mouth, teeth or chin? If Yes, explain.

7 Yes No Are you in pain now? If Yes, explain.

II. PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

- Chest pain (angina) Blood in stools Frequent vomiting Fainting spells
Diarrhea or constipation Jaundice Recent significant weight loss Frequent urination
Dry mouth Fever Difficulty urinating Excessive thirst
Night sweats Ringing in ears Difficulty swallowing Persistent cough
Headaches Swollen ankles Coughing up blood Dizziness
Joint pain or stiffness Bleeding problems Blurred vision Shortness of breath
Blood in urine Bruise easily Sinus problems

III. PLEASE CHECK IF YOU HAVE HAD, OR HAVE ANY OF THE FOLLOWING:

- Heart disease AIDS/HIV Psychiatric care Surgeries
Osteoporosis Hospitalization Family history of heart disease Thyroid disease
Heart attack Artificial joint Diabetes Asthma
Stomach problems or ulcers Hepatitis Family history of diabetes Heart defects
Tumors or cancer Heart murmurs Chemotherapy Herpes
Sexually transmitted disease Rheumatic fever Radiation Arthritis/Rheumatism
Canker or cold sores Skin disease Anemia Hardening of arteries
Liver disease High blood pressure Emphysema/other lung disease Eye disease
Kidney/bladder disease Seizures Stroke Transplants
Cosmetic surgery Eating disorders Tuberculosis



ADULT CONFIDENTIAL MEDICAL HISTORY

IV. PLEASE CHECK IF YOU ARE ALLERGIC TO, OR IF YOU HAVE HAD A REACTION TO ANY OF THE FOLLOWING:

- Aspirin, Valium, Tetracycline, Darvon, Demerol, Vicodin, Codeine, Penicillin, Percodan, Latex, Metal/Plastics, Erythromycin, Food, Nitrous oxide, Local anesthetic (Novacaine or Xylocaine)

Please list other allergies:

V. PLEASE CHECK IF YOU ARE TAKING OR IN THE LAST THREE MONTHS, HAVE TAKEN ANY OF THE FOLLOWING:

- Recreational drugs, Tobacco in any form, Over-the-counter medicines, Antibiotics, Alcohol, Supplements, Weight loss medications, Aspirin, Bisphosphonate (Fosamax)

Please list other medications:

VI. WOMEN ONLY (PLEASE CIRCLE)

- 1 Yes No Are you or could you be pregnant? If Yes, what month?
2 Yes No Are you nursing?
3 Yes No Are you taking birth control pills?

VII. ALL PATIENTS (PLEASE CIRCLE)

- 1 Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If Yes, please explain.
2 Yes No Have you ever been pre-medicated for dental treatment? If Yes, why?
3 Yes No Have you ever taken Fen-phen? If Yes, when?
4 Yes No Is there any issue or condition that you would like to discuss with the orthodontist in private?

VIII. PLEASE LIST ALL OF THE MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

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RELEASE AND ASSIGNMENT

The practice of dentistry involves treating the whole person. If the orthodontist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of orthodontic treatment.

I authorize the orthodontist to contact my physician.

Patient's Signature *Date*

Physician's Name *Phone Number*

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my health and /or medication dosage. Furthermore, I will not hold my orthodontist, or any other member of her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature *Date*

Orthodontist Signature *Date*