BRACELiNE

Medical Dental History Form For Adult Patients

DATE DD / MM / YYYY

PATIENT

Last Name:		First name(s):	
Title: Mr. O Mrs. O Ms. O Miss. O Dr. O Other:		I prefer to be called:	
Birth date:	Sex: Male O Female O	ID / Passport #:	
Marital Status: Single O Married O Separated O Divorced O Widowed O			
Home address:			
Home phone:		Occupation:	
Cell phone:		Employer:	
Work phone:			
Email:			

CONFIDENTIAL

CLOSEST RELATIVE

Last Name:		First name(s):	
Title: Mr. O Mrs. O Ms. O Miss. O Dr. O Other:		I prefer to be called:	
Home address: (if different from patient's)			
Home phone:		Work phone:	
Cell phone:		Email:	

DENTIST

Dentist's Name:		Address:	
Last seen:		Reason:	
Next appointment:		Other specialists:	

PHYSICIAN

Physician's Name:		Address:	
Last seen:		Reason:	
Next appointment:			

Other Physician's Name:		Address:	
Last seen:		Reason:	
Next appointment:			

FINANCIAL RESPONSIBILITY

Last Name:		First name(s):	
Home address: (if different from above)		Who will be responsible for bringing the patient to orthodontic appointments?	
Home phone:		Work phone:	
Cell phone:		Email:	

INITIAL

BRACELiNE

Medical Dental History Form For Adult Patients

Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation.
For the following questions mark yes, no, or don't know/understand (dk/u).

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, or major injuries?
yes ○ no ○ dk/u ○ Any injuries to face, head, neck?
yes ○ no ○ dk/u ○ Arthritis or joint problems?
yes ○ no ○ dk/u ○ Endocrine or thyroid problems?
yes ○ no ○ dk/u ○ Diabetes or low sugar?
yes ○ no ○ dk/u ○ Kidney problems?
yes ○ no ○ dk/u ○ Cancer, tumor, radiation treatment or chemotherapy?
yes ○ no ○ dk/u ○ Stomach ulcer, hyperacidity, acid reflux?
yes ○ no ○ dk/u ○ Immune system problems?
yes ○ no ○ dk/u ○ History of osteoporosis?
yes ○ no ○ dk/u ○ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
yes ○ no ○ dk/u ○ AIDS or HIV positive?
yes ○ no ○ dk/u ○ Hepatitis, jaundice or other liver problem?
yes ○ no ○ dk/u ○ Polio, mononucleosis, tuberculosis, pneumonia?
yes ○ no ○ dk/u ○ Seizures, fainting spells, neurologic problem?
yes ○ no ○ dk/u ○ Mental health disturbance or depression?
yes ○ no ○ dk/u ○ Vision, hearing, or speech problems?
yes ○ no ○ dk/u ○ History of eating disorder (anorexia, bulimia)?
yes ○ no ○ dk/u ○ High or low blood pressure?
yes ○ no ○ dk/u ○ Excessive bleeding or bruising, anemia?
yes ○ no ○ dk/u ○ Chest pain, shortness of breath, tire easily, swollen ankles?
yes ○ no ○ dk/u ○ Heart defects, heart murmur, rheumatic heart disease?
yes ○ no ○ dk/u ○ Angina, arteriosclerosis, stroke or heart attack?
yes ○ no ○ dk/u ○ Skin disorder (other than common acne)?
yes ○ no ○ dk/u ○ Do you eat a well-balanced diet?
yes ○ no ○ dk/u ○ Frequent headaches or migraines?
yes ○ no ○ dk/u ○ Frequent ear infections, colds, throat infections?
yes ○ no ○ dk/u ○ Asthma, sinus problems, hayfever?
yes ○ no ○ dk/u ○ Tonsil or adenoid condition?
yes ○ no ○ dk/u ○ Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following:
yes ○ no ○ dk/u ○ Local anesthetics (novocaine, lidocaine, xylocaine)
yes ○ no ○ dk/u ○ Latex (gloves, balloons)
yes ○ no ○ dk/u ○ Aspirin
yes ○ no ○ dk/u ○ Ibuprofen (Motrin, Advil)
yes ○ no ○ dk/u ○ Penicillin
yes ○ no ○ dk/u ○ Other antibiotics
yes ○ no ○ dk/u ○ Metals (jewelry, clothing snaps)
yes ○ no ○ dk/u ○ Acrylics
yes ○ no ○ dk/u ○ Plant pollens
yes ○ no ○ dk/u ○ Animals
yes ○ no ○ dk/u ○ Foods
yes ○ no ○ dk/u ○ Other substances

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 injured primary or permanent teeth?
yes ○ no ○ dk/u ○ Any sensitive or sore teeth?
yes ○ no ○ dk/u ○ Bleeding gums, bad taste or mouth odor?
yes ○ no ○ dk/u ○ Jaw fractures, cysts, infections?
yes ○ no ○ dk/u ○ Any teeth treated with root canals or pulpotomies?
yes ○ no ○ dk/u ○ "Gum boils," frequent canker sores or cold sores?
yes ○ no ○ dk/u ○ History of speech problems or speech therapy?
yes ○ no ○ dk/u ○ Difficulty breathing through nose?
yes ○ no ○ dk/u ○ Food impaction between the teeth?
yes ○ no ○ dk/u ○ Mouth breathing habit or snoring at night?
yes ○ no ○ dk/u ○ History of speech problems?
yes ○ no ○ dk/u ○ Frequent oral habits (sucking finger, chewing pen, etc.)?
yes ○ no ○ dk/u ○ Teeth causing irritation to lip, cheek or gums?
yes ○ no ○ dk/u ○ Abnormal swallowing (tongue thrust)?
yes ○ no ○ dk/u ○ Tooth grinding or clenching?
yes ○ no ○ dk/u ○ Clicking, locking in jaw joints?
yes ○ no ○ dk/u ○ Soreness in jaw muscles or face muscles?
yes ○ no ○ dk/u ○ Ringing in ears, difficulty in chewing or opening jaw?
yes ○ no ○ dk/u ○ Have you ever been treated for "TMJ" or "TMD" problems?
yes ○ no ○ dk/u ○ Any broken or missing fillings?
yes ○ no ○ dk/u ○ Any serious trouble associate with previous dental treatment?
yes ○ no ○ dk/u ○ Have you ever been diagnosed with gum disease or pyorrhea?
yes ○ no ○ dk/u ○ Have you ever had an orthodontic consultation or treatment before now?

GENERAL INFORMATION

What concerns you about your teeth?
Who suggested that you might need orthodontic treatment?
Why did you select our office?
Have you had any orthodontic treatment or consultations before?
Have any other family members been treated in this office? Please name them.
Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain.
Who referred you to our office?
Do you play any musical instruments?
Do you do any contact sport/hobbies that may be dangerous to the teeth?

INITIAL

BRACELiNE

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication	Taken for
1.	
2.	
3.	

Have you ever taken any medications to strengthen your bones? Please describe.	
Do you take antibiotic pre-medication before any dental procedures?	
Do you or have you ever had a substance abuse problem?	
Do you chew or smoke tobacco?	
Have you noticed any changes in your face or jaws?	
Any other physical problems?	
How often do you brush?	
How often do you floss?	
Are you pregnant?	
Are you trying to become pregnant?	

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders	
Diabetes	
Arthritis	
Severe allergies	
Unusual dental problems	
Jaw size imbalance	
Other family medical conditions?	

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

PATIENT'S SIGNATURE

DD / MM / YYYY

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my medical or dental health.

PATIENT'S SIGNATURE

DD / MM / YYYY

MEDICAL HISTORY UPDATES OR CHANGES

Changes

PATIENT'S SIGNATURE

DENTAL STAFF SIGNATURE

DD / MM / YYYY

nges

PATIENT'S SIGNATURE

DENTAL STAFF SIGNATURE

DD / MM / YYYY

INITIAL