

MEDICAL INFORMATION RECORD - ADULT

Patient's Name _____
(First) (M.I.) (Last)

Birth Date _____ Age _____ Sex: M F

Address _____

City _____ Postal Code _____

Tel. _____ Bus. or Mobile _____

Email _____

Occupation _____

Employer _____

Bus. Address _____

Patient's Dentist _____

Patient's Physician _____

How did you become acquainted with our office? _____

Please describe the reason(s) for seeking orthodontic treatment:

In case of Emergency, we should contact:

Name _____

Relationship _____

Tel. _____ Bus. or Mobile _____

Address: _____

MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible care. All information is strictly private, and is protected by doctor-patient confidentiality. The orthodontist will review your medical history and explain any questions that you do not understand.

Please fill out the entire form (both sides).

1. Are you being treated for any medical condition at this time or have you been treated for a medical condition within the past two years? Yes No

If yes, please explain:

2. When was your last medical check-up?

3. Has there been a change in your health within the past two years? Yes No

If yes, please explain:

4. Are you currently taking any medications, non-prescription drugs, or herbal supplements? Yes No

If yes, please explain:

5. Do you have any allergies? Yes No

If yes, please list using the categories below:

a) Medications

b) Latex and/or rubber by-products

c) Other (e.g. foods, hayfever)

6. Do you ever have an adverse reaction to any medications, injections or anaesthetics? Yes No
If yes, please explain:

7. Have you ever had your adenoids and/or tonsils removed? Yes No

8. Have you ever been diagnosed with asthma? Yes No

9. Have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes No

10. Do you have a prosthetic or artificial joint? Yes No

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV, radiotherapy, chemotherapy)? Yes No

12. Have you ever had hepatitis, jaundice or a liver disorder? Yes No

13. Do you have a bleeding problem or bleeding disorder? Yes No

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain: Yes No

15. Have you ever been diagnosed with the following?
(please check any current and past diagnoses that apply)

- | | | | |
|-----------------------|--------------------------|-------------------------|--------------------------|
| chest pain, angina | <input type="checkbox"/> | lung disease | <input type="checkbox"/> |
| rheumatic fever | <input type="checkbox"/> | steroid therapy | <input type="checkbox"/> |
| heart attack | <input type="checkbox"/> | cancer | <input type="checkbox"/> |
| mitral valve prolapse | <input type="checkbox"/> | stomach ulcers | <input type="checkbox"/> |
| heart murmur | <input type="checkbox"/> | arthritis | <input type="checkbox"/> |
| shortness of breath | <input type="checkbox"/> | seizures/epilepsy | <input type="checkbox"/> |
| pacemaker | <input type="checkbox"/> | kidney disease | <input type="checkbox"/> |
| diabetes | <input type="checkbox"/> | thyroid disease | <input type="checkbox"/> |
| tuberculosis | <input type="checkbox"/> | drug/alcohol dependency | <input type="checkbox"/> |
| stroke | <input type="checkbox"/> | nervous disorders | <input type="checkbox"/> |

16. Are there any conditions or diseases not listed above that you have had? Yes No
If yes, please explain:

17. **Women:** Are you breastfeeding or pregnant? Yes No

If pregnant, what is the expected delivery date?

DENTAL HISTORY

1. Are you nervous during dental treatment? Yes No

2. Are you a mouth breather while sleeping or awake (or both)? Yes No

3. Have you ever had a habit such as thumb or finger sucking, nail biting, lip sucking, grinding teeth, or an unusual swallow pattern? Yes No

4. Have you ever been informed of any missing or extra permanent teeth? Yes No

5. Have there been any injuries to your face, mouth, or teeth? Yes No

6. Have you experienced any jaw joint noises, jaw joint pain, or limited jaw movement? Yes No

7. Have you previously consulted an orthodontist? Yes No

8. Has any member of your family had orthodontic treatment? Yes No

To the best of my knowledge, the above information is correct. If there is a change in my health history, or my medications change, I will inform the orthodontist at the next appointment.

When appropriate or necessary, the orthodontist may send and discuss my health information with other involved health professionals.

Date _____

Signature _____

Additional Notes: