* ADULT MEDICAL QUESTIONNAIRE *

GENERAL PATIENT INFORMATION

Date: _____ Date of Birth: _____Age: _____ Sex: M_____ F____

Name: _____Preferred: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Business: _____ Cell _____

Dentist: _____City: _____ Phone: _____

How did you hear about our office? _____

Major reason for seeking an orthodontic consultation: _____

FAMILY INFORMATION

(circle one) Married Divorced Separated Single

Employer's name and address: _____

_____

SSN: _____-_____-_____ Occupation: _____

Dental Insurance: _____ Phone Number: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer's name and address: _____

_____

SSN: _____-_____-_____ Birth Date: _____

Dental Insurance: _____ Phone Number: _____

Names and Ages of Children: _____

(Please fill out other side)

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MEDICAL HISTORY

General health: (circle one) Good Fair Poor Height:_____ Weight:_____

Please check Yes or No and what year:

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
Arthritis	❑	❑	___	Emotional	❑	❑	___	S.T.D.	❑	❑	___
Endocrine	❑	❑	___	Glaucoma	❑	❑	___	Rheumatic fever	❑	❑	___
Hepatitis	❑	❑	___	Adenoids	❑	❑	___	Ear/Nose	❑	❑	___
Tonsils	❑	❑	___	Blood/bleeding problems	❑	❑	___	Fainting	❑	❑	___
Heart disorder/ murmur	❑	❑	___	Diabetes	❑	❑	___	H.I.V.	❑	❑	___
Allergies	❑	❑	___	Epilepsy	❑	❑	___	Bone disorder	❑	❑	___
Other	❑	❑	___	Hospitalized	❑	❑	___	Lung disorder	❑	❑	___

Please give us any additional medical information or details: _____

_____

Presently under medical attention for: _____

Do you require antibiotic pre-medication prior to dental work? _____

If yes, which antibiotics do you take? _____

DENTAL HISTORY

Date of last dental check up: _____

Any history of trauma to teeth/face? _____

Any oral habits? _____

Breathing: _____ Nose _____ Mouth _____ Snoring _____ Difficulty at night?

Jaw/Joint (TMJ) Problems?_____ ❑ Noise ❑ Ear Aches/Ringing ❑ Soreness/Stiffness

Have you had or ever been treated for TMJ?_____

	YES	NO	YEAR		YES	NO	YEAR
Worn or sore teeth?	❑	❑	_____	Headaches or joint problems?	❑	❑	_____
Bone or gum recession	❑	❑	_____	Speech difficulty	❑	❑	_____
Loose teeth	❑	❑	_____	Bruxism and/or clenching	❑	❑	_____

Please explain any dental problems: _____

How did you become aware of the orthodontic problem? _____

Is this your first visit as a patient to an orthodontic office? _____