

CONFIDENTIAL

**Member
American Association of
Orthodontists**

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ADULT

Patient's Last Name _____ First _____ Middle _____
Name of Physician _____
Physician's Address _____ Physician's Phone No. _____

*For the following questions circle **yes, no, or don't know/understand (dk/u)**. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.*

- 1. Are you in good health? _____ **yes no dk/u**
- 2. Has there been any change in health in the last year? **yes no dk/u**
- 3. Date of last physical exam _____
- 4. Are you now under medical care? _____ **yes no dk/u**
If so, for what? _____
- 5. Have you ever had a serious illness or operation? **yes no dk/u**
If so, explain _____
- 6. Do you have or have you ever had any of the following?
 - A. Rheumatic fever or rheumatic heart disease _____ **yes no dk/u**
 - B. Congenital heart disease _____ **yes no dk/u**
 - C. Cardiovascular disease (heart trouble, heart murmur, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) _____ **yes no dk/u**
 - D. Allergy or hay fever _____ **yes no dk/u**
 - E. Asthma _____ **yes no dk/u**
 - F. Hives or skin rash _____ **yes no dk/u**
 - G. Fainting spells _____ **yes no dk/u**
 - H. Diabetes _____ **yes no dk/u**
 - I. Hepatitis, jaundice or liver disease _____ **yes no dk/u**
 - J. Inflammatory rheumatism (painfully swollen joints) _____ **yes no dk/u**
 - K. Arthritis _____ **yes no dk/u**
 - L. Stomach ulcers _____ **yes no dk/u**
 - M. Kidney trouble _____ **yes no dk/u**
 - N. Tuberculosis _____ **yes no dk/u**
 - O. Persistent cough or cough up blood _____ **yes no dk/u**
 - P. AIDS or HIV Positive _____ **yes no dk/u**
 - Q. Sexually transmitted disease _____ **yes no dk/u**
 - R. Epilepsy or seizure disorder _____ **yes no dk/u**
 - S. Artificial joint prosthesis _____ **yes no dk/u**
 - T. Substance abuse (alcoholism, drug addiction) _____ **yes no dk/u**
- 7. Do you have pain in chest upon exertion? _____ **yes no dk/u**
- 8. Are you ever short of breath after mild exercise? _____ **yes no dk/u**
- 9. Do your ankles swell? _____ **yes no dk/u**
- 10. Do you get short of breath when you lie down, or do you require extra pillows to sleep? _____ **yes no dk/u**
- 11. Have you had abnormal bleeding associated with previous surgery, extractions, or accidents? _____ **yes no dk/u**
- 12. Have you ever required a blood transfusion? _____ **yes no dk/u**
- 13. Do you have any blood disorders such as anemia, etc.? **yes no dk/u**
- 14. Have you ever had surgery or x-ray treatment for a tumor growth, or other condition? _____ **yes no dk/u**
- 15. Are you taking any of the following?
 - A. Antibiotics or sulfa drugs _____ **yes no dk/u**
 - B. Anticoagulants (blood thinners) _____ **yes no dk/u**
 - C. Medicine for high blood pressure _____ **yes no dk/u**

- D. Cortisone or steroids _____ **yes no dk/u**
- E. Tranquilizers _____ **yes no dk/u**
- F. Aspirin or anti-inflammatory agent _____ **yes no dk/u**
- G. Dilantin or other anti-convulsant _____ **yes no dk/u**
- H. Insulin, Tolbutamide, Orinase or similar drug _____ **yes no dk/u**
- I. Digitalis or drugs for heart trouble _____ **yes no dk/u**
- J. Nitroglycerin _____ **yes no dk/u**
- K. Narcotic Analgesic _____ **yes no dk/u**
- L. Birth Control "pill" _____ **yes no dk/u**
- M. Alcohol, Antabuse _____ **yes no dk/u**
- N. Recreational drugs _____ **yes no dk/u**
- O. Any Other? _____

- 16. Are you allergic to or have you ever reacted adversely to any of the following?
 - A. Local anesthetics (Novocain, etc) _____ **yes no dk/u**
 - B. Penicillin or other antibiotics _____ **yes no dk/u**
 - C. Aspirin or anti-inflammatory drugs _____ **yes no dk/u**
 - D. Barbiturates, sedatives, or sleeping pills _____ **yes no dk/u**
 - E. Narcotic analgesics _____ **yes no dk/u**
 - F. Any other? _____

WOMEN

- 17. Are you pregnant? _____ **yes no dk/u**
If so, How far along are you? _____

If there are any changes later to this history record or medical status, I will so inform this practice. I have read and understand the above questions. 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.

Signature of patient _____ Date _____

Medical History Update or Changes: _____ Date: _____ Comments: _____ Initials: _____
