American Association of
Orthodontists

Patient #: ____________________

Date: ____________

CONFIDENTIAL

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM
- ADULT -

Patient's Last Name: ____________________ First Name: ____________________ Middle Name/Initial: ________

Birth Date: ______________ Age: ______ Sex: Male ☐ Female ☐ I prefer to be called: ____________________

Patient's Address: ____

City: ____________________ State/Province: ____________ Zip/Postal Code: ____________

S.S.N./S.I.N.: ______________ Home Phone #: ______________ Cell Phone #: ______________

Pager #: ______________ E-Mail Address: ____________________ Years at above address: ________

If less than 5 years at current address, previous address: ____

Years at previous address: ____________ Patient is: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Occupation: ______________ Employer: ____________________ Years with Employer: ________

Business Phone #: ______________

Name of Spouse/Closest Relative: ____________________ Phone # (if different than yours): ______________

Relationship to you: ______________ Employer: ______________ Occupation: ______________

Address (if different than yours): ____

City: ____________________ State/Province: ____________ Zip/Postal Code: ____________

Name of Patient's Dentist: ____

Date Last Seen: ______________ Reason: ____

Name of Patient's Physician(s): ____

Phone #(s).: ____

Date Last Seen: ______________ Reason: ____

Who suggested that you might need orthodontic treatment? ____

Why did you select our office? ____

Who is financially responsible for this account? ____

Last Name: ____________________ First Name: ____________________ Middle Name/Initial: ________

Address (if different that patient's): ____

Phone #: ______________

City: ____________________ State/Province: ____________ Zip/Postal Code: ____________

INSURANCE INFORMATION

Insurance Coverage for Orthodontic Treatment? Yes ☐ No ☐

Primary Policy Holder's Name: ______________________ S.S.N./S.I.N.: ______________

Birth Date: ______________ Employed By: ______________________

Dental Insurance Company: ______________ Group #: __________ Phone #: __________

Secondary Policy Holder's Name: ______________________ S.S.N./S.I.N.: ______________

Birth Date: ______________ Employed By: ______________________

Dental Insurance Company: ______________ Group #: __________ Phone #: __________

For the following questions mark 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.

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, any major accidents?
☐yes ☐no ☐dk/u Rheumatoid or arthritic conditions?
☐yes ☐no ☐dk/u Endocrine or thyroid problems?
☐yes ☐no ☐dk/u Kidney problems?
☐yes ☐no ☐dk/u Diabetes?
☐yes ☐no ☐dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐yes ☐no ☐dk/u Stomach ulcer or hyperacidity?
☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐yes ☐no ☐dk/u Problems of the immune system?
☐yes ☐no ☐dk/u AIDS or HIV positive?
☐yes ☐no ☐dk/u Hepatitis, jaundice or liver problem?
☐yes ☐no ☐dk/u Fainting spells, seizures, epilepsy or neurological problem?
☐yes ☐no ☐dk/u Mental health disturbance or depression?
☐yes ☐no ☐dk/u Vision, hearing, tasting or speech difficulties?
☐yes ☐no ☐dk/u Loss of weight recently, poor appetite?
☐yes ☐no ☐dk/u History of eating disorder (anorexia, bulimia)?
☐yes ☐no ☐dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐yes ☐no ☐dk/u High or low blood pressure?
☐yes ☐no ☐dk/u Tired easily?
☐yes ☐no ☐dk/u Chest pain, shortness of breath or swelling ankles?
☐yes ☐no ☐dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐yes ☐no ☐dk/u Skin disorder?
☐yes ☐no ☐dk/u Do you have a well-balanced diet?
☐yes ☐no ☐dk/u Frequent headaches, colds or sore throats?
☐yes ☐no ☐dk/u Eye, ear, nose or throat condition?
☐yes ☐no ☐dk/u Hayfever, asthma, sinus trouble or hives?
☐yes ☐no ☐dk/u Tonsil or adenoid conditions?
☐yes ☐no ☐dk/u Osteoporosis?

Allergies or reactions to any of the following:

☐yes ☐no ☐dk/u Local anesthetics (Novocaine or Lidocaine)
☐yes ☐no ☐dk/u Aspirin
☐yes ☐no ☐dk/u Ibuprofen (Motrin, Advil)
☐yes ☐no ☐dk/u Penicillin or other antibiotics
☐yes ☐no ☐dk/u Sulfa drugs
☐yes ☐no ☐dk/u Codeine or other narcotics
☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)
☐yes ☐no ☐dk/u Latex (gloves, balloons)
☐yes ☐no ☐dk/u Vinyl
☐yes ☐no ☐dk/u Acrylic
☐yes ☐no ☐dk/u Animals
☐yes ☐no ☐dk/u Foods (specify) ______________
☐yes ☐no ☐dk/u Other substances (specify) ______________

☐yes ☐no ☐dk/u Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication __________ Taken for __________
Medication __________ Taken for __________
Medication __________ Taken for __________
Medication __________ Taken for __________
Medication __________ Taken for __________
Medication __________ Taken for __________
Medication __________ Taken for __________

☐yes ☐no ☐dk/u Do you currently have or ever had a substance abuse problem?
☐yes ☐no ☐dk/u Do you chew or smoke tobacco?
☐yes ☐no ☐dk/u Operations? Describe: ______________
☐yes ☐no ☐dk/u Hospitalized? Describe: ______________
☐yes ☐no ☐dk/u Other physical problems or symptoms? Describe: ______________
☐yes ☐no ☐dk/u Being treated by another health care professional?
For: ______________
Date of most recent physical exam? ______________

Do you have any other medical conditions that we should know about?
____

WOMEN ONLY

☐yes ☐no ☐dk/u Are you pregnant?

☐yes ☐no ☐dk/u Are you anticipating becoming pregnant?

FAMILY MEDICAL HISTORY

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

Bleeding disorders ______________________________

Diabetes ______________________________

Arthritis ______________________________

Severe allergies ______________________________

Unusual dental problems ______________________________

Jaw size imbalance ______________________________

Any other family medical conditions that we should know about?

____

DENTAL HISTORY

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 otherwise injured primary (baby) or permanent teeth?

☐yes ☐no ☐dk/u Teeth sensitive to hot or cold; teeth throb or ache?

☐yes ☐no ☐dk/u Jaw fractures, cysts or mouth infections?

☐yes ☐no ☐dk/u "Dead teeth" or root canals treated?

☐yes ☐no ☐dk/u Bleeding gums, bad taste or mouth odor?

☐yes ☐no ☐dk/u Periodontal "gum problems"?

☐yes ☐no ☐dk/u Food impaction between teeth?

☐yes ☐no ☐dk/u "Gum boils", frequent canker sores or cold sores?

☐yes ☐no ☐dk/u Thumb, finger, or sucking habit? Until what age______?

☐yes ☐no ☐dk/u Abnormal swallowing habit (tongue thrusting)?

☐yes ☐no ☐dk/u History of speech problems?

☐yes ☐no ☐dk/u Mouth breathing habit, snoring or difficulty in breathing?

☐yes ☐no ☐dk/u Tooth grinding or jaw clenching?

☐yes ☐no ☐dk/u Any pain, clicking or locking in jaw or ringing in the ears?

☐yes ☐no ☐dk/u Any pain or soreness in the muscles of the face or around the ears?

☐yes ☐no ☐dk/u Difficulty in chewing or jaw opening?

☐yes ☐no ☐dk/u Have you ever been treated for "TMD" or "TMJ" problems?

☐yes ☐no ☐dk/u Aware of loose, broken or missing restorations (fillings)?

☐yes ☐no ☐dk/u Any teeth irritating cheek, lip, tongue or palate?

☐yes ☐no ☐dk/u Concerned about spaced, crooked or protruding teeth?

☐yes ☐no ☐dk/u Aware or concerned about under or over developed jaw?

☐yes ☐no ☐dk/u Any relative with similar tooth or jaw relationships?

☐yes ☐no ☐dk/u Any wisdom tooth problems?

☐yes ☐no ☐dk/u Had periodontal (gum) treatment?

☐yes ☐no ☐dk/u Had any serious trouble associated with any previous dental treatment?

☐yes ☐no ☐dk/u Been under another dentist's care?

Specialist ______________________________

Other ______________________________

☐yes ☐no ☐dk/u Ever had a prior orthodontic examination or treatment?

☐yes ☐no ☐dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: ______________ Floss: ______________

What is your primary concern? Why are you here? ______________________________

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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: ______________________________ Date Signed: ______________
(Patient)

Signed: ______________________________ Date Signed: ______________
(Dental staff member)

I understand that where appropriate, credit bureau reports may be obtained. Consent is given to take a panoramic x-ray today, to be used for more information and for a better preliminary diagnosis at no charge. This x-ray will remain the property of this office.

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ______________________________

____

____

Signed: ______________________________ Date Signed: ______________
(Patient)

Signed: ______________________________ Date Signed: ______________
(Dental staff member)

NAME ______ AGE ______ SEX ______ CASE # ______

1. ANGLE CLASSIFICATION AND RELATION OF SEGMENTS

	RIGHT SIDE		LEFT SIDE	
	MOLAR	CUSPID	MOLAR	CUSPID
CLASS I				
CLASS II				
DIV II				
CLASS III				

2. DENTITION

RIGHT																	LEFT
	8	7	6	E 5	D 4	C 3	B 2	A 1	A 1	B 2	C 3	D 4	E 5	6	7	8	
	8	7	6	5 E	4 D	3 C	2 B	1 A	1 A	2 B	3 C	4 D	5 E	6	7	8	

3. ARCH LENGTH - MAX - EXCESS ☐ ADEQUATE ☐ DEFICIENT ☐ AMT. ______ MM

MAN - EXCESS ☐ ADEQUATE ☐ DEFICIENT ☐ AMT. ______ MM

4 321 | 123 CROWDED ☐ EVEN ☐ SPACED ☐ AMT. ______ MM

321 | 123 CROWDED ☐ EVEN ☐ SPACED ☐ AMT. ______ MM

5. CROSSBITE RIGHT ☐ LEFT ☐ MAX. BUCCAL ☐ MAX. LINGUAL ☐ NARROW ☐

6. OVERBITE NORMAL ☐ OPEN BITE ☐ (______ MM) CLOSE BITE ☐ ______ %

7. OVERJET - CROSSBITE ☐ EDGE TO EDGE ☐ NORMAL ☐ EXCESSIVE ☐ (AMT. ______ MM)

8. CURVE OR SPEE - DEEP ☐ NORMAL ☐ FLAT ☐ REVERSED ☐

9. MEDIAN LINE - MAXILLARY MIDLINE TO MID-SIGITAL ______|______

MANDIBULAR MIDLINE REST. ______|______ OCCLUSION ______|______

10. PATH OF CLOSURE - UNRESTRICTIVE ☐ RESTRICTIVE ☐ CONTACT AND MESIALLY ☐

PSEUDO CLASS III ☐ CONTACT & DISTALLY ☐ SLIDES R ☐ L ☐

11. TMJ - CLICKS ☐ PAIN ☐ RESTRICTIVE MOVEMENT ☐ ROM Open ____mm (R)____mm (L)____mm

EAR ACHE S R ☐ L ☐ HEAD ACHES R ☐ L ☐

12. WIDTH OF MOLARS ______ mm

13. LIP POSTURE - TOGETHER ☐ TOGETHER STRAINED ☐ APART ☐

14. LIP MUSCLE TONE - HYPO ☐ NORMAL ☐ HYPER ☐

15. ABNORMAL FRENUM - NONE ☐ UPPER ☐ LOWER ☐ LINGUAL ☐

16. TONSILS AND ADENOIDS - NONE ☐ NORMAL ☐ LARGE AND A PROBLEM ☐

17. ERUPTION PATTERN - EARLY ☐ NORMAL ☐ LATE ☐

18. PROFILE - RETRUSIVE ☐ FLAT ☐ PROTRUSIVE ☐ DOUBLE PROTRUSIVE ☐

SATISFACTORY ☐ CONCAVE ☐

19. HABITS - TONGUE THRUST ☐ FRONTAL ☐ LATERAL ☐

LIP BITING ☐ FINGER OR THUMB SUCKING ☐ MOUTH BREATHING ☐

FINGERNAIL BITING ☐ OTHER ______

20. ORAL HYGIENE - EXCELLENT ☐ FAIR ☐ POOR ☐

21. DISPOSITION OF CASE - TREAT NOW ☐ NO TREATMENT ☐ RECALL ☐ ______ MONTHS

22. DIAGNOSTIC RECORD APPOINTMENT ______ CONSULTATION DATE ______

23. APPOINTMENTS ______

24. LETTER SENT - DDS ______ PT ______

24. ESTIMATE ______

DATE	