DR. GEORGE WALKER ORTHODONTICS
ADULT MEDICAL DENTAL HISTORY FORM

Date_____
Patient Last Name_____First_____Middle_____
Birth date_____ Age___ Sex___ Patient Home#_____ Cell#_____
Address_____E-mail_____
Patient is ___Single ___Married ___Widowed ___Separated ___Divorced
Additional Responsible Party Name (s)_____ Relationship to Patient_____
(if different) Address_____ Phone#_____
Person to contact if we cannot reach you_____ Phone# _____
Name of Patient's Dentist_____ Date of Last Dental Exam/Cleaning_____
Name of Patient's Physician_____ Date of Last Physical_____
Other Family Member's Treated_____

For the following questions **please circle yes, no, or don't know/understand (dk/u). Please also circle the specific condition applicable.** 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----------

Yes No dk/u Pre-mature birth, low birth weight?
Yes No dk/u Birth defects, hereditary conditions?
Yes No dk/u Bone fractures, any major accidents?
Yes No dk/u Rheumatic or arthritic condition?
Yes No dk/u Mental health or behavioral problem?
Yes No dk/u ADD or ADHD?
Yes No dk/u Kidney problem?
Yes No dk/u Endocrine or thyroid problem?
Yes No dk/u Vision, hearing, tasting, or speech difficulties?
Yes No dk/u Cancer or been treated for a tumor?
Yes No dk/u Stomach ulcer or stomach hyperactivity?
Yes No dk/u Polio, mono, tuberculosis, pneumonia?
Yes No dk/u History of speech problems?
Yes No dk/u Skin disorder?
Yes No dk/u High or low blood pressure?
Yes No dk/u Fainting spells, seizures, epilepsy or neurological problem?
Yes No dk/u Chest pain, shortness of breath, swelling ankles?
Yes No dk/u Tires easily?
Yes No dk/u Cardiovascular problem: heart trouble, heart attack, angina, coronary insufficiency, stroke, arteriosclerosis, heart defect or rheumatic heart?
Yes No dk/u Do you have a normal and good diet
Yes No dk/u Loud snoring?
Yes No dk/u Feel tired or sleepy during the day?

Yes No dk/u Hepatitis, jaundice, or liver problem?
Yes No dk/u Diabetes?
Yes No dk/u Loss of weight recently, poor appetite?
Yes No dk/u Excessive bleeding, bruise easily, anemia, or bleeding disorder?
Yes No dk/u Mouth breathing habit or difficulty in breathing?
Yes No dk/u Eye, ear, nose, throat condition?
Yes No dk/u Seasonal allergies, hay fever, asthma, sinus trouble, hives?
Yes No dk/u Drug reactions?_____
Yes No dk/u Seasonal, environmental, other allergies?_____
Yes No dk/u Allergy to latex, nickel or any metal?
Yes No dk/u Are you in good health?
Yes No dk/u Tonsil or adenoid condition or treatment?
Yes No dk/u Frequent colds, headaches, or sore throats?
Yes No dk/u Does patient currently have, or ever had a substance abuse problem?
Yes No dk/u Problems of the immune system?
Yes No dk/u AIDS or HIV positive?
Yes No dk/u Sexually transmitted disease?
Yes No dk/u Operations (surgical procedures)?_____
Yes No dk/u Hospitalized for _____date_____
Yes No dk/u Being treated by another health care professional? For_____

Is pre-medication for dental procedures recommended?_____

Yes No dk/u Has anyone observed you stop breathing during the day?

*Please list all medications, non-prescription medicine (for what condition), & nutrient supplements patient is currently taking:
_____
_____
_____
_____

Yes No dk/u Does patient regularly take aspirin or other NSAIDS (non-steroidal anti-inflammatory medication)? For what condition? _____

Female patients:
Yes No dk/u Are you pregnant?
Yes No dk/u Are you anticipating becoming pregnant?

----------**DENTAL HISTORY**----------

Yes No dk/u Any dental or facial trauma?

Yes No dk/u Chipped or otherwise injured permanent teeth?

Yes No dk/u Have any permanent teeth been removed?

Yes No dk/u History of supernumerary(extra) or congenitally missing teeth?

Yes No dk/u "Dead teeth", root canals treated?

Yes No dk/u Crowns or bridges present?

Yes No dk/u Aware of loose, broken, missing restorations (fillings)?

Yes No dk/u Any wisdom tooth problems?

Yes No dk/u Jaw fractures, cysts, mouth infections?

Yes No dk/u Teeth sensitive to hot or cold; teeth throb or ache?

Yes No dk/u Periodontal "Gum problems"?

Yes No dk/u Any previous periodontal (gum) treatments?

Yes No dk/u "Gum boils", frequent canker sores, cold sores?

Yes No dk/u Bleeding gums, bad taste, mouth odor?

Yes No dk/u Food impaction between teeth?

Yes No dk/u Abnormal swallowing habit (tongue thrusting)?

Yes No dk/u Does patient experience any pain or soreness in the muscles of the face or around the ears?

Yes No dk/u Difficulty chewing or opening jaw?

Yes No dk/u Any pain in jaw?

Yes No dk/u Have you ever been treated for "TMJ" problems? (for jaw joint or facial muscle pain?)

Yes No dk/u Tooth grinding, jaw clenching, clicking, or locking?

Yes No dk/u Any teeth irritating cheek, lip, tongue, palate?

Yes No dk/u Has patient had any problems associated with previous dental treatment?

Yes No dk/u Has patient had a prior orthodontic examination or treatment?
When? _____Type of treatment _____

Please check all concerns:

___ spaces ___crowding (not enough space)
___alignment (crooked teeth) ___missing teeth
___ crossbite ___ jaw growth problem
___impacted teeth ___room for permanent tooth eruption
___protruding teeth ___ TMJ (jaw joint) pain
___general dentist recommendation/concern_____
___Other_____

Yes No dk/u Any relative with similar tooth or jaw relationship?

Yes No dk/u Recent dental care?_____

or specialists care?_____

Yes No dk/u Taking any form of fluoride? What?_____

How often do you brush? _____ Floss _____

I have read and understood 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 inform this practice.

Signature of patient / Date