

Medical & Dental History-Adult

Your answers to the following questions are extremely important for an accurate diagnosis. Thank you for your patience in answering the following questions.

Patient's Name: _____ Nickname: _____ Date: _____

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Birth defects or hereditary problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking prescription or non-prescription medicine? Please list _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone fractures, any major accidents? | <input type="checkbox"/> Yes <input type="checkbox"/> No Current or previous substance abuse? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid or arthritic conditions? | <input type="checkbox"/> Yes <input type="checkbox"/> No Operations? Describe _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine or thyroid problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No Hospitalized? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No Other physical problems or symptoms? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Being treated by another health care professional? For _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer or treated for a tumor? | <input type="checkbox"/> Yes <input type="checkbox"/> No Date of most recent exam _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach ulcer or hyperacidity? | <input type="checkbox"/> Yes <input type="checkbox"/> No Primary (baby) teeth removed that were not loose? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Polio, mono, tuberculosis, pneumonia? | <input type="checkbox"/> Yes <input type="checkbox"/> No Permanent teeth removed? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Problems of the immune system? | <input type="checkbox"/> Yes <input type="checkbox"/> No "Extra" or congenitally missing teeth? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS or HIV positive? | <input type="checkbox"/> Yes <input type="checkbox"/> No Chipped or otherwise injured primary (baby) or permanent teeth? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sexually transmitted disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No Teeth sensitive to hot or cold; teeth throb or ache? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis, liver problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw fractures, cysts, mouth infections? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No "Dead Teeth", root canals treated? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting spells, seizures, epilepsy or neurological problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding gums, bad taste, mouth odor? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mental health or behavioral problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No Periodontal "Gum Problems"? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Vision, hearing, tasting or speech difficulties? | <input type="checkbox"/> Yes <input type="checkbox"/> No Food impaction between teeth? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of weight recently, poor appetite? | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent canker sores, cold sores? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive bleeding, anemia or bleeding disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No Current thumb, finger, sucking habit? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High or low blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No Past sucking habit until _____ years old? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tires easily? | <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal swallowing habit (tongue thrusting)? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain, shortness of breath or swelling ankles? | <input type="checkbox"/> Yes <input type="checkbox"/> No History of speech problems? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiovascular problem heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart? | <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth breathing habit, snoring, difficulty in breathing? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Skin disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No Tooth grinding, jaw clenching, clicking, locking? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No A normal and good diet? | <input type="checkbox"/> Yes <input type="checkbox"/> No Pain in jaw or ringing in the ears? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent headaches, colds or sore throats? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eye, ear, nose, throat condition? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hay fever, asthma, sinus trouble, hives? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsil or adenoid conditions? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies or drug reactions? | |

- Yes No Have you ever been treated for “TMD” problems (your jaw joint and facial muscle pain?)
- Yes No Pain or soreness in the muscles of the face, or around the ears?
- Yes No Difficulty encountered in chewing or jaw opening?
- Yes No Aware of loose, broken or missing restorations (fillings)?
- Yes No Any teeth irritating cheek, lip, tongue, or palate?
- Yes No Have you ever had periodontal (gum) treatment?
- Yes No Concerned about spaced, crooked, protruding teeth?

- Yes No Aware or concerned about under or over developed jaw?
- Yes No Any relative with similar tooth, jaw relationship or profile?
- Yes No Any wisdom tooth problems?
- Yes No Serious trouble associated with any previous dental treatment?
- Yes No Have you ever had a prior orthodontic examination or treatment? If treated, explain briefly _____
- Yes No Have you recently been under another dentist’s care? Specialist: _____ Other: _____

FEMALE PATIENT

- Yes No Are you pregnant?
- Yes No Are you taking birth control pills?
- Yes No Are you anticipating becoming pregnant?

Date of most recent dental examination: _____
 How often do you brush? _____ floss? _____
 What is your primary concern? _____

Realizing that successful treatment greatly depends upon the patient’s complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____

I have read and understand the above questions. I will not hold Dr. Stacy Miller or any member or 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 (Patient) _____ Date: _____