



**American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM - ADULT**

Date _____

Patient's Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ Sex _____ Home Phone No. _____

Patient's Address - Street _____

City _____ State _____ Zip Code _____

Patient is Single , Married , Widowed , Separated , Divorced .

Name of spouse/closest relative _____ Phone No. _____

His/Her Address _____ City _____ State _____ Zip _____

Name of Dentist _____

Address _____ Phone No. _____

Name of Physician (s) _____

Address _____ Phone No. _____

Occupation _____ Social Security No. _____ Business Phone No. _____

Insurance coverage yes ___ no ___

Primary Insurance Co. _____ Policy No. _____

Secondary Insurance Co. _____ Policy No. _____

In case we cannot reach you:

Person to contact _____ Phone No. _____

Present Weight _____ Height _____ Musical Instrument Played _____

Favorite Sports, Hobbies & Avocations _____

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.

MEDICAL HISTORY

- | | |
|---|--|
| yes no dk/u Birth defects or hereditary problems? | yes no dk/u Hepatitis, jaundice or liver problem? |
| yes no dk/u Bone fractures, any major accidents? | yes no dk/u AIDS or HIV Positive? |
| yes no dk/u Rheumatoid or arthritic conditions? | yes no dk/u Sexually transmitted disease? |
| yes no dk/u Endocrine or thyroid problems? | yes no dk/u Fainting spells, seizures, epilepsy or neurologic disease? |
| yes no dk/u Kidney problems? | yes no dk/u Mental health or behavioral problems? |
| yes no dk/u Diabetes? | 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 Loss of weight recently, poor appetite? |
| yes no dk/u Stomach ulcer or hyperacidity? | yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder? |
| yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia? | yes no dk/u High or low blood pressure? |
| yes no dk/u Problems of the immune system? | yes no dk/u Easily tired? |

