Adult Patient Health History Form

Thompson Orthodontics
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Today's Date: _____

Patient's Name: _____ _____ _____ Date of Birth: _____
(First) (Middle) (Last)

Has Orthodontic treatment been recommended for you? Yes No

If yes, by whom? Family Dentist Family Physician Friend Other

Who referred you to our office? _____

Have you had any previous orthodontic treatment? Yes No

If yes, where? _____

Has any member of your family, or a close friend, had Orthodontic treatment? Yes No

If yes, who? _____

Where were they treated? _____

What were their feelings regarding treatment results? Excellent Good Fair Poor

What do you consider the main benefit of Orthodontic Correction?

Cosmetic Functional Psychological Emotional Other

Please Explain: _____

What would you like Orthodontic treatment to do for you? _____

_____

_____

Are you self-conscious of your teeth? Yes No

If yes, indicate the degree: Very Moderately Some

What is your attitude toward Orthodontic treatment? Excellent Good Fair Poor

What do you anticipate in the way of patient cooperation? Excellent Good Fair Poor

Does anyone else in the family have a similar Orthodontic problem? Yes No

Have any baby teeth or permanent teeth been removed by your dentist? Yes No

Any major falls or accidents involving the head, face or teeth? Yes No

Any difficulty in breathing through the nose (awake and/or asleep)? Yes No

Any tooth clenching or grinding (at night)? Yes No

Have you had any speech therapy/speech concerns? Yes No

Thumb or finger sucking? Yes No
To what age: _____

Other oral habits (fingernails, ice, etc.) _____

Patient Name: _____
Today's Date: _____

Health History:

Tonsils and/or adenoids removed Yes No
When: _____

Rheumatic Fever Yes No

Drug or other allergies Yes No
List allergies: _____

Diabetes Yes No

Heart Condition Yes No
Please Specify: _____

Smoke/Tobacco Yes No

Infectious Disease Yes No
What: _____

Joint Problems/Arthritis Yes No

GI Problems Yes No

Kidney Problems Yes No

Liver Problems Yes No

Breathing Condition Yes No

Skin Disorder/Condition Yes No

Medication taken regularly Yes No
Medication List: _____

Other Medical Concerns Yes No
Please explain: _____

Health during infancy and early childhood: Excellent Good Fair Poor

Present Health Excellent Good Fair Poor

Have you ever had serious illness or injury/surgery? Yes No

What and When: _____

Your Physician: _____

When were you last seen by a physician? Date: _____ Reason: _____

Your Dentist: _____

When were you last checked by the dentist? Date: _____ Reason: _____

Were any problems found at that time? Yes No

Do you make regular visits to the dentist? Yes No

Signature: _____ Date: _____

Print Name: _____

Withholding medical information may result in possible health complications as a result of treatment