



PATIENT HISTORY – ADULT

CONFIDENTIAL INFORMATION _____

DATE _____/_____/_____

PERSONAL INFO

Last: _____, First _____, MI: _____ I prefer to be called: _____

Is the Patient; Financial; and Professional Information on the New Patient Evaluation form still current? _____

DENTAL HISTORY

What is your primary concern/why are you here? _____

Do you have a present or past dental history of any of the following:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Extra teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractured facial or jaw bones
<input type="checkbox"/> Yes <input type="checkbox"/> No	Missing teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw cysts, infections or jaw surgery
<input type="checkbox"/> Yes <input type="checkbox"/> No	Teeth knocked loose	<input type="checkbox"/> Yes <input type="checkbox"/> No	Concern about under or overdeveloped jaws
<input type="checkbox"/> Yes <input type="checkbox"/> No	Teeth fractured from trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech or swallowing difficulties
<input type="checkbox"/> Yes <input type="checkbox"/> No	Teeth sensitive/throb/ache		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding gums, bad taste/bad breath		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Treated for periodontal/gum problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	TMJ problems (jaw joint)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Food packs in between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Teeth grinding or jaw clenching
<input type="checkbox"/> Yes <input type="checkbox"/> No	Missing or defective fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw joint clicks or pops
<input type="checkbox"/> Yes <input type="checkbox"/> No	Spaced, crooked or protruding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw locks open or closed
<input type="checkbox"/> Yes <input type="checkbox"/> No	Wisdom tooth problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Facial muscle pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Gum boils, canker sores, cold sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty chewing or jaw opening
<input type="checkbox"/> Yes <input type="checkbox"/> No	Thumb or finger sucking habit	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent headaches or ringing in the ears
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cleft lip or palate	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in neck or upper back
<input type="checkbox"/> Yes <input type="checkbox"/> No	Serious problems with dental care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Facial nerve tingling, paralysis

How many times/day do you: brush _____ How many times/week do you floss: _____

Yes No Have you had previous orthodontic treatment? If so when: _____

Describe what treatment was accomplished. _____

Were you pleased with the results at the time or have the teeth relapsed? _____

Anything else you would like to tell us? _____

Physician's Name or Clinic _____ Phone # (____) _____ - _____
 Physician's Address: Street _____ City _____ Zip _____

When was your last medical checkup? Mo _____ Year _____,

Are you being treated for any chronic health conditions? _____

Any medical symptoms not currently under treatment? _____

Are you taking any medications, prescription, over the counter or herbal/dietary supplements: Yes No

Medication _____ Taken for _____ How long _____

Medication _____ Taken for _____ How long _____

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Medication _____ Taken for _____ How long _____

Medication _____ Taken for _____ How long _____

Have you ever had chemotherapy or taken medication for osteoporosis? _____

Hospitalizations/Surgical procedures: _____

Tobacco usage: Chew, Smoke, Pack years _____; Any substance abuse history Yes No

Women Only: Are you pregnant or planning pregnancy over the next 2 -3 years? Yes No

Now or in the past have you had:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Birth defects or hereditary problems		Cardiovascular problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid or arthritic conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack, angina, arteriosclerosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine or thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Obstructive Pulmonary Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur, rheumatic heart disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital heart defects
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer, tumor, radiation or chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve prolapse
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach ulcer or acid reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Valve replacement
<input type="checkbox"/> Yes <input type="checkbox"/> No	Immune system, HIV, AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain, short of breath, swollen ankles
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis, jaundice or liver problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	High or low blood pressure
<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding, bruising or anemia disorders
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bone fractures, any major accidents	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthetic joint replacement		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting spells, seizures, neurologic disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Growth problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental health problems, depression
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating disorders, bulimia, anorexia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent colds or sore throats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio, MS, nerve disorders or paralysis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye, ear, nose or throat condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision, hearing, tasting difficulties
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay fever, asthma, sinusitis		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsil or adenoid condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing, snoring, sleep apnea

Notes on medical history: _____

Allergies or reactions to the following:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Local anesthetics novocaine, lidocaine, etc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex, exam gloves, balloons
<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin, Motrin, Advil, Naprosyn, ibuprofen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vinyl, acrylic, plastics
<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin or other antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Animals
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foods (specify)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine or other narcotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other substances (specify)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Metals, jewelry		

I have read and understand the above questions. I will not hold my orthodontist or any member of the 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: _____

Mark J. Bentele, DDS, MS

Dated: _____ th day of _____ 200__

Dated: _____ th day of _____ 200__