EMPRESS ORTHODONTICS

ADULT MEDICAL/DENTAL HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

NAME: MR./MRS./MISS/MS./DR. _____

DATE OF BIRTH (dd/mm/yy):____/____/____ **HOME TELEPHONE**: (_____)_____-_____ **CELL** (_____)_____-_____

ADDRESS _____ **APARTMENT/UNIT NUMBER** _____

CITY_____ **POSTAL CODE** _____ **E-MAIL ADDRESS**_____

EMPLOYER/OCCUPATION: _____

MAY WE CONTACT YOU AT WORK? YES ❑ NO ❑ **WORK** (_____)_____-_____

NAME, ADDRESS & PHONE OF DENTIST _____

DATE OF LAST DENTAL CHECKUP _____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

IN CASE OF AN EMERGENCY, WE SHOULD NOTIFY: NAME _____

RELATIONSHIP _____ **DAY-TIME TELEPHONE** (_____)_____-_____

MEDICAL DOCTOR _____ **TELEPHONE** (_____)_____-_____

The following information is required to enable us to provide you with the best possible dental care. All the information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please complete the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If yes, please explain

YES ❑ NO ❑ NOT SURE/MAYBE❑

_____

2. When was your last medical checkup?

_____

3. Has there been any change in your general health in the past year? If yes, please explain

YES ❑ NO ❑ NOT SURE/MAYBE ❑

_____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list

YES ❑ NO ❑ NOT SURE/MAYBE ❑

_____

5. Do you have any allergies? If you answered yes, please list using the categories below:

a) medications YES ❑ NO ❑ NOT SURE/MAYBE ❑

b) latex/rubber products

c) other e.g. hayfever, foods

_____

6. Do you have or have you ever had any of the following? Please check the applicable.

❑ Asthma	❑ Sleep apnea/snoring	❑ Heart Disease/ Heart Murmur	❑ Liver Disease	❑ Clenching/ Grinding	❑ Drug/alcohol dependency
❑ Osteoporosis	❑ Hormone problems	❑ Tuberculosis	❑ Diabetes	❑ Cancer	❑Seizures/epilepsy
❑ Cleft lip/palate	❑ Skin problems	❑ Tonsil/Adenoid Problems	❑ Growth problems	❑ Immune disease/ HIV	❑ Pacemaker
❑ Arthritis	❑ Emotional/Behavioral disorders	❑ Cold sores	❑ Steroid therapy	❑ Anemia	❑ Thyroid disease

❑Other, please specify: _____

7. Why are you seeking an orthodontic consultation/what don't you like about your teeth or bite?

_____

8. Have you consulted an orthodontist previously? YES ❑ NO ❑ Dr. _____

_____

9. Have you had previous orthodontic treatment? (Including braces or other appliances) YES ❑ NO ❑

If yes, when and by whom: _____

_____

10. Has your dentist told you that you are missing a tooth/teeth or have impacted teeth? YES ❑ NO ❑

_____

11. Have you ever had any serious head or face injuries? YES ❑ NO ❑

If yes, explain: _____

_____

12. Do you wear a nightguard? YES ❑ NO ❑

_____

13. Do you have a history of thumbsucking/fingersucking habit? YES ❑ NO ❑ NOT SURE/MAYBE ❑

_____

14. Are you a mouthbreather? YES ❑ NO ❑

_____

15. Do you smoke or chew tobacco? YES ❑ NO ❑

_____

16. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
YES ❑ NO ❑ NOT SURE/MAYBE ❑

_____

To the best of my knowledge, the above information is correct:

PATIENT SIGNATURE _____ DATE _____