SCRIPPS POWAY ORTHODONTICS
CHRISTOPHER MAULIK, DMD, MDS

ADULT MEDICAL / DENTAL HISTORY FORM

Date: _____

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐ Prefers To Be Called: _____

Patient's Address: _____

City: _____ State: _____ Postal Code: _____ Home Phone No.: (_____) _____-_____

E-mail address: _____ Cell phone: (_____) _____-_____

Preferred method of appointment reminder: Text ☐ Email ☐ Preferred Method to receive general correspondence: Mail ☐ Email ☐

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Other family members treated here: _____

Name Of Dentist: _____ Date Last Seen: _____

Name Of Physician (s): _____ Date Last Seen: _____

Who Is Financially Responsible For This Account? Last Name: _____ First Name: _____ MI: _____

Address (if different from patient's): _____

Years at address: _____

If less than five years, previous address: _____

Phone No. (if different than patient's): (_____) _____-_____

Employer: _____ How many years?_____

Insurance Coverage For Dental Treatment? Yes ☐ No ☐ Insurance Coverage For Orthodontic Treatment? Yes ☐ No ☐

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____ Birth Date: _____

Employed By: _____ Dental Insurance Company: _____ Group No. _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____ Birth Date: _____

Employed By: _____ Dental Insurance Company: _____ Group No. _____

Medical Insurance Company: _____ Group No. _____

PRIMARY CONCERN

What is your primary concern? Why are you here? _____

_____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

For the following questions mark 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

Now or in the past, have you had:

☐**yes** ☐**no** ☐**dk/u** Bone fractures, any major accidents?
☐**yes** ☐**no** ☐**dk/u** Rheumatoid or arthritic conditions?
☐**yes** ☐**no** ☐**dk/u** Endocrine or thyroid problems?
☐**yes** ☐**no** ☐**dk/u** Kidney problems?
☐**yes** ☐**no** ☐**dk/u** Diabetes?
☐**yes** ☐**no** ☐**dk/u** Cancer, tumor, radiation or chemotherapy?
☐**yes** ☐**no** ☐**dk/u** Stomach ulcer or hyperacidity?
☐**yes** ☐**no** ☐**dk/u** Polio, mononucleosis, tuberculosis or pneumonia?
☐**yes** ☐**no** ☐**dk/u** Problems of the immune system?
☐**yes** ☐**no** ☐**dk/u** AIDS or HIV positive?
☐**yes** ☐**no** ☐**dk/u** Hepatitis, jaundice or liver problem?
☐**yes** ☐**no** ☐**dk/u** Fainting spells, seizures, epilepsy or neurological problem?
☐**yes** ☐**no** ☐**dk/u** Mental health disturbance or behavioral problem?
☐**yes** ☐**no** ☐**dk/u** Vision, hearing, tasting or speech difficulties?
☐**yes** ☐**no** ☐**dk/u** Loss of weight recently, poor appetite?
☐**yes** ☐**no** ☐**dk/u** History of eating disorder (anorexia, bulimia)?
☐**yes** ☐**no** ☐**dk/u** Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐**yes** ☐**no** ☐**dk/u** High or low blood pressure?
☐**yes** ☐**no** ☐**dk/ u** Tires easily?
☐**yes** ☐**no** ☐**dk/u** Chest pain, shortness of breath or swelling ankles?
☐**yes** ☐**no** ☐**dk/u** Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐**yes** ☐**no** ☐**dk/u** Do you eat a well-balanced diet?
☐**yes** ☐**no** ☐**dk/u** Frequent headaches, colds or sore throats?
☐**yes** ☐**no** ☐**dk/u** Eye, ear, nose or throat condition?
☐**yes** ☐**no** ☐**dk/u** Hayfever, asthma, sinus trouble or hives?
☐**yes** ☐**no** ☐**dk/u** Tonsil or adenoid conditions?
☐**yes** ☐**no** ☐**dk/u** Do you currently have/had a substance abuse problem?
☐**yes** ☐**no** ☐**dk/u** Do you chew or smoke tobacco?
☐**yes** ☐**no** ☐**dk/u** Operations? Describe: _____
☐**yes** ☐**no** ☐**dk/u** Other physical problems or symptoms?
Describe: _____

WOMEN ONLY

☐**yes** ☐**no** ☐**dk/u** Are you pregnant?

MEDICINES

☐**yes** ☐**no** ☐**dk/u** Are you currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/cancers: such as Zometa (zolendronic acid), Aredia (pamidronate), Didronel (etidronate)?

☐**yes** ☐**no** ☐**dk/u** Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses: such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate) Skelid (tiludronate), Didronel (etidronate)?

☐**yes** ☐**no** ☐**dk/u** Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Date of most recent physical exam? _____
Are there any other medical conditions that we should be aware of?

_____

Allergies or reactions to any of the following:

☐**yes** ☐**no** ☐**dk/u** Local anesthetics (Novocaine or Lidocaine)
☐**yes** ☐**no** ☐**dk/u** Aspirin
☐**yes** ☐**no** ☐**dk/u** Ibuprofen (Motrin, Advil)
☐**yes** ☐**no** ☐**dk/u** Penicillin or other antibiotics
☐**yes** ☐**no** ☐**dk/u** Sulfa drugs
☐**yes** ☐**no** ☐**dk/u** Metals (jewelry, clothing snaps)
☐**yes** ☐**no** ☐**dk/u** Latex (gloves, balloons)
☐**yes** ☐**no** ☐**dk/u** Vinyl
☐**yes** ☐**no** ☐**dk/u** Acrylic

DENTAL HISTORY

Now or in the past, have you had:

☐**yes** ☐**no** ☐**dk/u** Permanent or "extra" (supernumerary) teeth removed?

☐**yes** ☐**no** ☐**dk/u** Supernumerary (extra) or congenitally missing teeth?

☐**yes** ☐**no** ☐**dk/u** Chipped or otherwise injured primary (baby) or permanent teeth?

☐**yes** ☐**no** ☐**dk/u** Teeth sensitive to hot or cold; teeth throb or ache?

☐**yes** ☐**no** ☐**dk/u** Jaw fractures, cysts or mouth infections?

☐**yes** ☐**no** ☐**dk/u** "Dead teeth" or root canals treated?

☐**yes** ☐**no** ☐**dk/u** Bleeding gums, bad taste or mouth odor?

☐**yes** ☐**no** ☐**dk/u** Periodontal "gum problems"?

☐**yes** ☐**no** ☐**dk/u** Food impaction between teeth?

☐**yes** ☐**no** ☐**dk/u** Thumb, finger, or sucking habit? Until what age _____

☐**yes** ☐**no** ☐**dk/u** Abnormal swallowing habit (tongue thrusting)?

☐**yes** ☐**no** ☐**dk/u** History of speech problems?

☐**yes** ☐**no** ☐**dk/u** Mouth breathing, snoring or difficulty in breathing?

☐**yes** ☐**no** ☐**dk/u** Tooth grinding, jaw clenching clicking or locking?

☐**yes** ☐**no** ☐**dk/ u** Any pain in jaw or ringing in the ears?

☐**yes** ☐**no** ☐**dk/u** Any pain or soreness in the muscles of the face or around the ears?

☐**yes** ☐**no** ☐**dk/u** Difficulty encountered in chewing or jaw opening?

☐**yes** ☐**no** ☐**dk/u** Any teeth irritating cheek, lip, tongue or palate?

☐**yes** ☐**no** ☐**dk/u** Concerned about spaced, crooked or protruding teeth?

☐**yes** ☐**no** ☐**dk/u** Aware or concerned about under or over developed jaw?

☐**yes** ☐**no** ☐**dk/u** Any relative with similar tooth or jaw relationships?

☐**yes** ☐**no** ☐**dk/u** Had periodontal (gum) treatment?

☐**yes** ☐**no** ☐**dk/u** Any serious trouble associated with any previous dental treatment?

☐**yes** ☐**no** ☐**dk/u** Ever had a prior orthodontic examination or treatment?

☐**yes** ☐**no** ☐**dk/u** Been under another dentist's care?
Specialist _____
Other _____

How often does you brush? _____ Floss? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/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: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental Staff Member)

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