MEDICAL AND DENTAL INFORMATION (ADULT)

DENTAL HISTORY :

Last visit to the dentist : ( ) 0-6 months ( ) 6-12 months ( ) + 12 months

Reason for orthodontic consultation : _____

Have you had a previous orthodontic consultation : ( ) yes ( ) no
If yes, did you have treatment? ( ) yes ( ) no

Are you apprehensive towards dental visits? ( ) yes ( ) no

Have you had an accident involving the head or neck area? ( ) yes ( ) no
Have you had an accident involving the teeth? ( ) yes ( ) no

Are you a mouth breather? ( ) yes ( ) no
Have you had any teeth extractions? ( ) yes ( ) no
Does your jaw crack? ( ) yes ( ) no
Do you suffer from T.M.J. ( ) yes ( ) no
Do you suffer from bleeding gums ? ( ) yes ( ) no
Do you suffer from teeth sensitivity? ( ) yes ( ) no

MEDICAL HISTORY :

Name and phone number of your family physician : _____
Date of your last medical exam : _____

Are you in good health? ( ) yes ( ) no, please explain : _____
Do you take any medicament? ( ) yes, which ones : _____( ) no

Are you pregnant? ( ) yes ( ) no

Are you taking any form of bisphosnates? ( ) no
yes, Fosamex ( ) Actonel ( ) Other _____
Do you suffer from osteoporosis? ( ) yes ( ) no

Are you a smoker? ( ) yes ( ) no

Do you suffer or have you suffered from… ?

Heart trouble ( ) Rheumatic fever ( ) Endocarditis ( ) Anemia ( )
Prolonged bleeding ( ) Frequent colds and sinusitis ( ) Tuberculosis or long disease ( )
Asthma ( ) Removal of tonsils or adnoids ( ) HIV virus ( )
Emotional problems ( ) Digestive problems ( ) Renal problems ( ) Diabetes ( )
Thyroid ( ) Epilepsy ( ) Skin disease ( ) Ophthalmic disease ( )
Liver disease ( ) Frequent headaches ( ) Fainting ( ) Ear problems ( )
High or low blood pressure ( ) Persistent cough ( ) Mononucleosis ( ) Cancer ( )
Bone disorder ( ) Nervous disorder ( ) Endocrine problems ( )
Allergies :latex : ( ) no ( ) yes medication _____food_____

Signature : _____ Date : _____