

# BRADFORD ORTHODONTICS

## ADULT MEDICAL/DENTAL HISTORY QUESTIONNAIRE

<b>PERSONAL INFORMATION</b>		
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 <input type="checkbox"/> NO <input type="checkbox"/> 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) metals, 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.

- |   |  |   |  |   |   |
|---|--|---|--|---|---|
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Sleep apnea/snoring | <input type="checkbox"/> Heart Disease/<br>Heart Murmur | <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> Clenching/<br>Grinding | <input type="checkbox"/> Drug/alcohol<br>dependency |
| <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Hormone problems    | <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Seizures/epilepsy          |
| <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Skin problems       | <input type="checkbox"/> Tonsil/Adenoid<br>Problems     | <input type="checkbox"/> Growth problems | <input type="checkbox"/> Immune disease/<br>HIV | <input type="checkbox"/> Pacemaker                  |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Cold sores                     | <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Thyroid disease            |

Other, please specify: \_\_\_\_\_

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

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**8.** Have you consulted an orthodontist previously? YES  NO  Dr. \_\_\_\_\_

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

If yes, when and by whom: \_\_\_\_\_

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

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

If yes, explain: \_\_\_\_\_

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

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

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**14.** Are you a mouthbreather? YES  NO

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

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

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

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_