KIDS FIRST
PEDIATRIC DENTISTRY

FIRST IMPRESSIONS
ORTHODONTICS

Adult Medical History

Welcome! We would like to welcome you to our office. Our goal is to help you achieve a beautiful smile while reaching and maintaining maximum oral health in a warm, courteous, safe and caring environment. Please fill out this form completely.

Today's Date: _____ Date of birth: _____

Name: _____

Home Address: _____

City/Town: _____ State: _____ Zip Code: _____

Home Phone #: _____ Mobile/Cell Phone #: _____

Best way to reach you? ☐ Home ☐ Cell/Mobile ☐ Work: _____

☐ Other: _____ ☐ e-mail: _____

Employer: _____

Occupation: _____

Spouse/Significant Other's Name: _____

Emergency Contact Name & Number: _____

Relation: _____

Any other family member(s) or friend(s) seen by us? _____

General Dentist: _____

Physician: _____

To whom may we thank for referring you to First Impressions? _____

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Medical History: Please Checkmark

- ☐ ADD, ADHD, PDD (Circle One)
- ☐ Abnormal Bleeding
- ☐ Allergies
- ☐ Allergies to drugs, substances
- ☐ Any Operations
- ☐ Any stay in a hospital
- ☐ Artificial Joints (hip, etc.)
- ☐ Asthma, Airway or Breathing Problems
- ☐ Autism, Asperger's Syndrome (circle one)
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy, Radiation Treatment
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Defect
- ☐ Convulsions/Epilepsy
- ☐ Diabetes
- ☐ Diet (special, restricted)
- ☐ Emphysema
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Handicap/Disabilities
- ☐ Hearing Impairment
- ☐ Heart Attack/Stroke
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High/Low Blood Pressure (circle one)
- ☐ HIV+/AIDS
- ☐ Kidney/Liver Problems
- ☐ Latex Sensitive
- ☐ Mitral Valve Prolapse
- ☐ Nervous/Anxious
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Psychiatric/Psychological Problems
- ☐ Rheumatics Fever
- ☐ Severe or Frequent Headaches
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea
- ☐ TB/Lung Disorders
- ☐ Thyroid Problems
- ☐ Tumors
- ☐ Ulcers/Stomach Disorders
- ☐ Venereal Disease

Please explain any medical problems that you may have: _____

_____

Are you currently under the care of a physician? Yes, for the follow condition: _____ No

Have you been a hospital patient during the past two (2) years? Yes No

Woman:

Are you pregnant? Yes: How many week(s) _____ No

Nursing? Yes No

Taking birth control pills? Yes No

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Please list all drugs that you are currently taking and the condition they are addressing:

Medication: _____ To Treat: _____

Medication: _____ To Treat: _____

Medication: _____ To Treat: _____

Medication: _____ To Treat: _____

Have you ever been treated with medications for abnormal bone conditions, cancer, osteoporosis or osteopenia? (If yes, please list the name of medication(s): (i.e.,Actonel, Aredia, Boneva, Fosamax, Zometa, etc.) _____ _____ _____

Please list all drug(s)/substances that you are allergic to:

_____ _____ _____

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Dental History:

Have you had any previous orthodontic consultation or had orthodontic treatment? Yes No

Why did you come to the orthodontist today? _____

_____

Date of last dental visit? _____

Did you have a full (panoramic) x-ray(s) taken? Yes: when? _____ No

Oral Surgery	Yes	No
Periodontal Treatment	Yes	No
Serious Injury (mouth/head)	Yes	No

If yes, please describe: _____

_____

Have you ever experienced?

Clicking or popping of jaw	Yes	No	Pain (ear, face, joint)	Yes	No
Difficulty in chewing	Yes	No	Problem opening, closing mouth	Yes	No
Headaches	Yes	No	Tired Jaws	Yes	No

Have you been diagnosed with sleep apnea or any nighttime sleeping disorders? Yes No

Do you have difficulty maintaining a regular sleeping pattern? Yes No

Do you frequently get blisters, cold sores or any other oral lesions? Yes No

Your current dental health is: Excellent Good Fair Poor

Do you grind your teeth?	Yes	No
Do you like your smile?	Yes	No
Do your gums ever bleed?	Yes	No

I understand the above information is necessary to provide me with orthodontic care in a safe, caring, confidential and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature: _____ Print Name: _____