

Charles H. Buchanan, D.D.S

Specialist In Orthodontics
1971 Western Avenue Albany, NY 12203 518-456-0001

Date _____

MEDICAL DENTAL HISTORY FORM ADULT

CONFIDENTIAL

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

Birth Date: _____ Age: _____ Sex: M _____ F _____ Patient's Nickname: _____

S.S.N./S.I.N.: _____ Home Phone No.: _____ Work Number: _____

Cell Phone Number: _____ E-mail Address: _____

Patient's Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Years At Above Address: _____ Patient Is: Single ___ Married ___ Widowed ___ Separated ___ Divorced ___

If Less Than 5 Years At Current Address, Previous Address: _____

Years At Previous Address: _____

Occupation: _____ Employer: _____ Years With Employer: _____

Name of Spouse/Closest Relative: _____ Phone No.: (if different than yours) _____

Relationship To You: _____ Address (if different than patient's): _____

City: _____ State: _____ Zip/Postal Code: _____

Name of Patient's Dentist: _____ Phone No.: _____

Dentist's Address: _____ City: _____ State: _____ Zip: _____

Date Last Seen: _____ Reason: _____

Name of Patient's Physician(s): _____ Phone No.: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____

Date Last Seen: _____ Reason: _____

Who Is Financially Responsible For This Account?

Last Name: _____ First Name: _____ Middle Name/Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone No. : _____ S.S.N./S.I.N.: _____

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.: _____

Who Suggested That Your Child 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 Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

___yes ___no ___dk/u Skin disorder?

___yes ___no ___dk/u Birth defects or hereditary problems?

___yes ___no ___dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

___yes ___no ___dk/u Bone fractures, any major accidents?

___yes ___no ___dk/u High or low blood pressure?

___yes ___no ___dk/u Rheumatoid or arthritic conditions?

___yes ___no ___dk/u Tired easily?

___yes ___no ___dk/u Endocrine or thyroid problems?

___yes ___no ___dk/u Chest pain, shortness of breath or swelling ankles?

___yes ___no ___dk/u Kidney problems?

___yes ___no ___dk/u History of eating disorder (anorexia, bulimia)?

___yes ___no ___dk/u Diabetes?

___yes ___no ___dk/u Vision, hearing, tasting or speech difficulties?

___yes ___no ___dk/u Cancer, tumor, radiation treatment or chemotherapy?

___yes ___no ___dk/u Mental health disturbance or depression?

___yes ___no ___dk/u Stomach ulcer or hyperacidity?

___yes ___no ___dk/u Tonsil or adenoid condition?

___yes ___no ___dk/u Polio, mononucleosis, tuberculosis, pneumonia?

___yes ___no ___dk/u Does patient eat a well balanced diet?

___yes ___no ___dk/u Problems of the immune system?

___yes ___no ___dk/u Hayfever, asthma, sinus trouble, or hives?

___yes ___no ___dk/u AIDS or HIV positive?

___yes ___no ___dk/u Frequent headaches, colds, or sore throats?

___yes ___no ___dk/u Hepatitis, jaundice or liver problem?

___yes ___no ___dk/u Fainting spells, seizures, epilepsy or neurological problem?

___yes ___no ___dk/u Eye, ear, nose or throat condition?

___yes ___no ___dk/u Loss of weight recently, poor appetite?

___yes ___no ___dk/u Osteoporosis

Allergies or reactions to any of the following:

___yes___no___dk/u Local anesthetics (Novocaine or Lidocaine)

___yes___no___dk/u Metals (jewelry, clothing snaps)

___yes___no___dk/u Ibuprofen (Motrin, Advil)

___yes___no___dk/u Aspirin

___yes___no___dk/u Penicillin or other antibiotics

___yes___no___dk/u Sulfa drugs

___yes___no___dk/u Codeine or other narcotics

___yes___no___dk/u Latex (gloves, balloons)

___yes___no___dk/u Vinyl

___yes___no___dk/u Acrylic

___yes___no___dk/u Animals

___yes___no___dk/u Foods(specify)_____

___yes___no___dk/u Other substances (specify)_____

___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_____

Medication_____ Taken for_____

Medication_____ Taken for_____

___yes___no___dk/u Do you currently have or ever 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 Hospitalized? Describe: _____

___yes___no___dk/u Other physical problems or symptoms? Describe: _____

___yes___no___dk/u Being treated by another health care professional? For: _____

Date of most recent physical exam? _____

Are there any other medical conditions that we should be aware of? _____

WOMEN ONLY

___yes___no___dk/u Are you pregnant?

___yes___no___dk/u Are you anticipating becoming pregnant?

DENTAL HISTORY

Now or in the past, have you had:

___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 Chipped or otherwise injured primary(baby) or permanent teeth?

___yes___no___dk/u "Dead teeth" or root canals treated?

___yes___no___dk/u Thumb, finger or sucking habit? Until what age?_____?

___yes___no___dk/u Bleeding gums, bad taste of mouth odor?

___yes___no___dk/u Mouth breathing habit, snoring, or difficulty in breathing?

___yes___no___dk/u Periodontal "gum problems"?

<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any pain or soreness in the muscles of the face or around the ears?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Food impaction between teeth?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Tooth grinding or jaw clenching?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Permanent or "extra" (supernumerary) teeth removed?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Supernumerary (extra) or congenitally missing teeth?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u History of speech problems?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any pain in jaw or ringing in the ears?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Abnormal swallowing habit (tongue thrusting)?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Difficulty encountered in chewing or jaw opening?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Aware of loose, broken or missing restorations (fillings)?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any teeth irritating cheek, lip, tongue or palate?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Concerned about space crooked or protruding teeth?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Aware or concerned about under or overdeveloped jaw?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u "Gum boils", frequent canker sores or cold sores?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Taking any forms of fluoride?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any relative with similar tooth or jaw relationships?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Had periodontal (gum) treatment?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any serious trouble associated with previous dental treatment?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Ever had a prior orthodontic examination or treatment?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Been under another dentist's care?	
Specialist _____	
Other _____	

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems?
If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Metabolic disturbances _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Any other family medical conditions that we should know about? _____

How often do you brush: _____ Floss: _____

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

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 made later to this history record or medical/dental status, I will so inform the practice.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)