

## Adult Orthodontic Medical History

PATIENT: Dr.  Mr.  Mrs.  Miss  Ms.

NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

(STREET)

(CITY)

(POSTAL CODE)

RESIDENCE TEL: \_\_\_\_\_

BUSINESS TEL: \_\_\_\_\_

CELLULAR: \_\_\_\_\_

EMAIL: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

DENTIST'S NAME: \_\_\_\_\_

DENTAL INSURANCE: Yes  No

1. WHAT ORTHODONTIC CONCERNS DO YOU HAVE ABOUT YOUR TEETH OR MOUTH?  
\_\_\_\_\_  
\_\_\_\_\_

2. HAVE YOU OR ANY OTHER MEMBER OF YOUR FAMILY EXPERIENCED ORTHODONTIC TREATMENT? Yes  No  (If yes, who?)  
\_\_\_\_\_  
\_\_\_\_\_

3. HAVE YOU SUFFERED ANY SEVERE ACCIDENTS INVOLVING: Face  Teeth  Jaws  None

4. DO YOU HAVE ALLERGIES RELATED TO: Asthma  Hayfever  Drugs  Latex  None

5. DO YOU HAVE DIFFICULTY BREATHING THROUGH YOUR NOSE? Yes  No

6. DO YOU HAVE OR DID YOU EVER HAVE ANY ORAL HABITS SUCH AS: Thumbsucking  Fingersucking  Tonguethrusting  None

Other

7. HAVE YOUR TONSILS AND/OR ADENOIDS BEEN REMOVED? Yes  No  (If so, when?)  
\_\_\_\_\_  
\_\_\_\_\_

8. HAVE YOU EXPERIENCED ANY COMPLEX OR UNUSUAL DENTAL TREATMENT? Yes  No

(If so, please explain.)  
\_\_\_\_\_  
\_\_\_\_\_

9. ARE YOU PRESENTLY IN GOOD GENERAL HEALTH? Yes  No  PHYSICIAN'S NAME: \_\_\_\_\_

10. ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE FOR ANYTHING THAT IS OTHER THAN ROUTINE? Yes  No

(If so, for what reason?)  
\_\_\_\_\_  
\_\_\_\_\_

11. ARE YOU CURRENTLY TAKING ANY MEDICATION? Yes  No  (If so, please list.)  
\_\_\_\_\_  
\_\_\_\_\_

12. HAVE YOU EVER BEEN ADMITTED TO A HOSPITAL? Yes  No  (If so, for what reason?)  
\_\_\_\_\_  
\_\_\_\_\_

13. HAVE YOU EVER EXPERIENCED ANY SERIOUS ILLNESSES SUCH AS: Rheumatic Fever  Auto Immune Disease  Hepatitis

Vascular Disorders  Artificial Joints, Heart Valves, etc.  Heart Disease  None  Other

Our office complies with privacy legislation, the regulations of the Royal College of Dental Surgeons of Ontario and the law. Please be assured that every team member in our office is committed to protecting your personal health information.

The above medical history is correct to the best of my knowledge. I authorize Drs. Luks to consult with and/or send reports to medical and/or dental practitioners as it relates to orthodontic treatment.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date