ADULT HEALTH HISTORY INFORMATION

Name: ____Date: ________________

What concerns you most about the thought of orthodontic treatment?

□ Appearance □ Cost □ How long □ Will it work □ Other ________________

	YES	NO
Do you have a health problem now? ………………………………………………….	□	□
Are you currently under a physicians care? ……………………………………………	□	□
Are you taking any medications? If so, describe ………………………………………	□	□
Have you had an unusual reaction to any medications? ……………………………….	□	□
Are you allergic to anything? If so, please list ………………………………………...	□	□
Have you had major surgery? If so, please list. ………………………………………	□	□
Have you been diagnosed or treated for (please circle): diabetes, epilepsy, asthma, stroke, arthritis, anemia, fainting, rheumatic fever, heart trouble, hepatitis, high blood pressure, emotional disturbances, endocrine disorders, prolonged bleeding or kidney trouble ……	□	□
Do you have a history of mouth breathing? ……………………………………………..	□	□
Do you have any speech problems? ……………………………………………………..	□	□
Do you have difficulty chewing or swallowing? ………………………………………..	□	□
Are you aware of tooth grinding or clenching during the day or night? ……………………..	□	□
Do you have a headache more than once a week? ………………………………………	□	□
Are you bothered by neck or shoulder pain? ……………………………………………	□	□
Do you have pain or noises when opening or closing your mouth? ……………………….	□	□
Have you ever had any severe head or face injuries? …………………………………...	□	□
Have you ever had permanent teeth removed? …………………………………………..	□	□
Have you ever had a previous orthodontic consultation or treatment? ……………………	□	□

What are your main concerns? ____

Additional comments or questions: ____

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Signature: ______________________________