RITTENHOUSE ORTHODONTICS

# MEDICAL INFORMATION RECORD - ADULT

**(please complete, print and bring the form to your appointment)**

Patient's Name _____
(First) (M.I.) (Last)

Birth Date _____ Age _____ Sex: M ☐ F ☐

Address _____

City _____ Postal Code _____

Tel. _____ Bus. or Mobile _____

Email _____

Occupation _____

Employer _____

Bus. Address _____

Patient's Dentist _____

Patient's Physician _____

How did you become acquainted with our office? _____

_____

_____

Please describe the reason(s) for seeking orthodontic treatment:

_____

_____

_____

In case of Emergency, we should contact:

Name _____

Relationship _____

Tel. _____ Bus. or Mobile _____

Address: _____

_____

## MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible care. All information is strictly private, and is protected by doctor-patient confidentiality. The orthodontist will review your medical history and explain any questions that you do not understand.

Please fill out the entire form (both sides).

1. Are you being treated for any medical condition at this time or have you been treated for a medical condition within the past two years? Yes ☐ No ☐
   If yes, please explain:

   _____

   _____

2. When was your last medical check-up?

   _____

3. Has there been a change in your health within the past two years? Yes ☐ No ☐
   If yes, please explain:

   _____

   _____

   _____

4. Are you currently taking any medications, non-prescription drugs, or herbal supplements? Yes ☐ No ☐
   If yes, please explain:

   _____

   _____

5. Do you have any allergies? Yes ☐ No ☐
   If yes, please list using the categories below:

   a) Medications

   _____

   b) Latex and/or rubber by-products

   _____

   c) Other (e.g. foods, hayfever)

   _____

6. Do you ever have an adverse reaction to any medications, injections or anaesthetics? Yes ☐ No ☐
If yes, please explain:

7. Have you ever had your adenoids and/or tonsils removed? Yes ☐ No ☐

8. Have you ever been diagnosed with asthma? Yes ☐ No ☐

9. Have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes ☐ No ☐

10. Do you have a prosthetic or artificial joint? Yes ☐ No ☐

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV, radiotherapy, chemo-therapy)? Yes ☐ No ☐

12. Have you ever had hepatitis, jaundice or a liver disorder? Yes ☐ No ☐

13. Do you have a bleeding problem or bleeding disorder? Yes ☐ No ☐

14. Have you ever been hospitalized for any illnesses or operations? Yes ☐ No ☐
If yes, please explain:

15. Have you ever been diagnosed with the following?
(please check any current and past diagnoses that apply)

| | | | |
|---|---|---|---|
| chest pain, angina | ☐ | lung disease | ☐ |
| rheumatic fever | ☐ | steroid therapy | ☐ |
| heart attack | ☐ | cancer | ☐ |
| mitral valve prolapse | ☐ | stomach ulcers | ☐ |
| heart murmur | ☐ | arthritis | ☐ |
| shortness of breath | ☐ | seizures/epilepsy | ☐ |
| pacemaker | ☐ | kidney disease | ☐ |
| diabetes | ☐ | thyroid disease | ☐ |
| tuberculosis | ☐ | drug/alcohol dependency | ☐ |
| stroke | ☐ | nervous disorders | ☐ |

16. Are there any conditions or diseases not listed above that you have had? Yes ☐ No ☐
If yes, please explain:

17. **Women:** Are you breastfeeding or pregnant? Yes ☐ No ☐
If pregnant, what is the expected delivery date?

## DENTAL HISTORY

1. Are you nervous during dental treatment? Yes ☐ No ☐

2. Are you a mouth breather while sleeping or awake (or both)? Yes ☐ No ☐

3. Have you ever had a habit such as thumb or finger sucking, nail biting, lip sucking, grinding teeth, or an unusual swallow pattern? Yes ☐ No ☐

4. Have you ever been informed of any missing or extra permanent teeth? Yes ☐ No ☐

5. Have there been any injuries to your face, mouth, or teeth? Yes ☐ No ☐

6. Have you experienced any jaw joint noises, jaw joint pain, or limited jaw movement? Yes ☐ No ☐

7. Have you previously consulted an orthodontist? Yes ☐ No ☐

8. Has any member of your family had orthodontic treatment? Yes ☐ No ☐

*To the best of my knowledge, the above information is correct. If there is a change in my health history, or my medications change, I will inform the orthodontist at the next appointment.*

*When appropriate or necessary, the orthodontist may send and discuss my health information with other involved health professionals.*

Date _____

Signature _____

Additional Notes: