Adult Patient Health History Form

Thompson Orthodontics
819 W. Main Street, Wilmington, OH 45177
1450 Columbus Ave. Ste. 101 Wash Ct Hs, OH 43160
(937)283-2020 Wilmington (740)335-2921 Wash Ct Hs Today's Date: ________________

Patient's Name: ____ Date of Birth: ______________________
(First) (Middle) (Last)

Has Orthodontic treatment been recommended for you? Yes No

If yes, by whom? Family Dentist Family Physician Friend Other

Who referred you to our office? ____

Have you had any previous orthodontic treatment? Yes No

If yes, where? ____

Has any member of your family, or a close friend, had Orthodontic treatment? Yes No

If yes, who? ____

Where were they treated? _____________________________________

What were their feelings regarding treatment results? Excellent Good Fair Poor

What do you consider the main benefit of Orthodontic Correction?

Cosmetic Functional Psychological Emotional Other

Please Explain: ____

What would you like Orthodontic treatment to do for you? _______________________________________

____

Are you self-conscious of your teeth? Yes No

If yes, indicate the degree: Very Moderately Some

What is your attitude toward Orthodontic treatment? Excellent Good Fair Poor

Do you think you will be cooperative with doctor's orders? Excellent Good Fair Poor

Does anyone else in the family have a similar Orthodontic problem? Yes No

Have any baby teeth or permanent teeth been removed by your dentist? Yes No

Any major falls or accidents involving the head, face or teeth? Yes No

Any difficulty in breathing through the nose (awake and/or asleep)? Yes No

Any tooth clenching or grinding (at night)? Yes No

Have you had any speech therapy/speech concerns? Yes No

Thumb or finger sucking? Yes No
To what age: ______________

Other oral habits (fingernails, ice, etc.) ____

Patient Name: ___________________________
Today's Date: __________________

Health History:

		Yes	No
Tonsils removed	When: ___________________________	Yes	No
Adenoids removed	When: ___________________________		
Rheumatic Fever		Yes	No
Drug or other allergies		Yes	No
List allergies: ____			
Diabetes		Yes	No
Heart Condition		Yes	No
Please Specify: ____			
Smoke/Tobacco		Yes	No
Infectious Disease		Yes	No
What: ____			
Joint Problems/Arthritis		Yes	No
GI Problems		Yes	No
Kidney Problems		Yes	No
Liver Problems		Yes	No
Breathing Condition		Yes	No
Skin Disorder/Condition		Yes	No
Medication taken regularly		Yes	No
Medication List: ____			
Other Medical Concerns		Yes	No
Please explain: ____			

Present Health   Excellent   Good   Fair   Poor

Have you ever had serious illness or injury/surgery?   Yes   No

What and When: ____

Your Physician: ___________________________________

When were you last seen by a physician?   Date: _______________   Reason: ____________________

Your Dentist: ______________________________________

When were you last checked by the dentist? Date: _______________   Reason: ____________________

Were any problems found at that time?   Yes   No

Do you make regular visits to the dentist?   Yes   No

Signature: ________________________________   Date: ______________________

Print Name: ______________________________

Withholding medical information may result in possible health complications as a result of treatment