DR. JAMES C. MAGESTRO
ORTHODONTIST

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ADULT MEDICAL DENTAL HISTORY

Date _____

Patient's Full Name _____

Birthdate _____ Age _____ Sex _____ Home Phone _____

Patient's Street Address _____

City _____ State _____ Zip Code _____

Occupation_____ Business Phone Number_____

Patient is: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Name of Spouse/closest relative _____

His/Her Address _____

Other Family Members Treated _____

Patient's Dentist _____ Patient's Physician _____

Musical Instruments, Sports, Hobbies _____

Dental Insurance Coverage yes _____ no _____ Social Security Number _____
Please present dental insurance card(s) at front desk.

In case we cannot reach you:

Person to contact _____ Phone _____

For the following questions circle 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

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Mental health or behavioral problem?
yes no dk/u Vision, hearing, tasting, speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u Excessive bleeding or bruising, anemia?
yes no dk/u High or low blood pressure?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer or ever treated for a tumor?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mono, tuberculosis, pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or liver problems?
yes no dk/u Fainting spells, seizures, epilepsy, neurological?
yes no dk/u Mouth breathing habit, snoring, difficulty breathing?
yes no dk/u Tires easily?
yes no dk/u Chest pain, shortness of breath, ankle swelling?
yes no dk/u Heart defects/problems?

yes no dk/u Skin disorder?
yes no dk/u Normal and healthful diet?
yes no dk/u Frequent headaches, colds or sore throats?
yes no dk/u Eye, ear, nose, throat condition?
yes no dk/u Hayfever, asthma, sinus trouble, hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Allergies or drug reactions?
yes no dk/u Are you taking medication, nutrient supplements or non-prescription medicine? Please name them.

_____

_____

_____

yes no dk/u Past or current substance abuse problem?
yes no dk/u Operations (surgical procedures)?
yes no dk/u Hospitalized for _____
yes no dk/u Other physical problems or symptoms?
yes no dk/u Being treated by another health care professional?
For _____
Date of last physical exam? _____

Female Patient

yes no dk/u Are you pregnant?
yes no dk/u Are you taking birth control pills?
yes no dk/u Are you anticipating becoming pregnant?

DENTAL HISTORY

yes no dk/u Supernumerary (extra) teeth?
yes no dk/u Congenitally missing teeth?
yes no dk/u Permanent teeth removed?
yes no dk/u Chipped or injured teeth?
yes no dk/u Teeth sensitive to hot or cold?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u Dead teeth, root canals?
yes no dk/u Periodontal "gum problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u Frequent canker sores, cold sores?
yes no dk/u Taking any forms of fluoride?
yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u History of speech problems?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Pain in jaw or ringing in the ears?
yes no dk/u Soreness in facial muscles or around ears?
yes no dk/u Difficulty chewing or opening jaw?
yes no dk/u Loose, broken/missing restorations (fillings)?
yes no dk/u Teeth irritating cheek, lip, tongue, palate?
yes no dk/u Concerned w/spaced, crooked, protruding teeth?
yes no dk/u Concerned about over/under developed jaw?
yes no dk/u Problems with wisdom teeth (third molars)?
yes no dk/u Any trouble with previous dental treatment?
yes no dk/u Previous orthodontic treatment, or ever wear a "retainer" or "bite plate"?
Last dental visit?
Approx. date _____
Specialist _____
yes no dk/u Previous periodontal gum treatment?
yes no dk/u Are you ready to cooperate w/wearing orthodontic appliances should they be indicated?

How often do you brush each day? _____ Floss each day? _____

What are your primary concerns? Why are you here? _____
_____
_____

Who referred you to our office? Dentist ____ Existing/Former Patient _____ Yellow Pages _____ Other _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during orthodontic treatment?

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. _____
Signature of patient

Medical/History Update or Changes:

Comments: _____
_____
_____

_____
Signature of patient Date