SWEET ORTHODONTICS
JOSEPH A. SWEET DMD, PC

ADULT MEDICAL HISTORY

Patient _____
Physician _____ City _____ Phone _____

Does the patient:

Yes	No	
☐	☐	Have any health problems? Explain _____
☐	☐	Take any medications? List _____
☐	☐	Have allergic reactions to medications? List _____
☐	☐	Currently see a physician? Explain _____
☐	☐	Receive blood transfusion? Reason _____
☐	☐	Had their tonsils and adenoids removed? When _____
☐	☐	Take medication for immunosuppressive disease? Explain _____
☐	☐	Take any medications for dietary conditions? e.g., phenphen _____

Please check if patient has had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Hives/Rash	☐	☐	Emotional Problems
☐	☐	Heart Surgery	☐	☐	Diabetes	☐	☐	Frequent Headaches
☐	☐	Rheumatic Fever	☐	☐	Kidney Disease	☐	☐	Nervous/Anxious
☐	☐	High Blood Pressure	☐	☐	Liver Disease/Hepatitis	☐	☐	Cancer
☐	☐	Prolonged Bleeding	☐	☐	Tuberculosis	☐	☐	Bone Disorders
☐	☐	Anemia	☐	☐	Bronchitis	☐	☐	Growth Disorders
☐	☐	Blood Disease	☐	☐	Asthma	☐	☐	Pregnant
☐	☐	Endocrine Disorder	☐	☐	Epilepsy/Seizures	☐	☐	Herpes (Fever Blisters)
☐	☐	Developmental Disorder	☐	☐	Fainting	☐	☐	Arthritis/Rheumatism

Any other conditions or problems that we should know about? _____
_____

Dentist _____ City _____ Phone _____

Frequency of dental checkups: Twice a yr ☐ Once a yr ☐ Only if problem exists ☐ Never ☐ Date of last visit _____

Is there any unfinished care to be completed with your dentist?	☐ Yes	☐ No	Explain: _____
Are you frightened about dental treatment?	☐ Yes	☐ No	Explain: _____
Have you had any unpleasant experience in a dental office?	☐ Yes	☐ No	Explain: _____
Have you had any face or dental injuries?	☐ Yes	☐ No	Explain: _____
Do you play any musical instruments?	☐ Yes	☐ No	What instrument? _____
Have you consulted with an orthodontist previously?	☐ Yes	☐ No	With whom? _____
Have teeth (either primary or permanent) been removed?	☐ Yes	☐ No	Explain: _____
Have you had any previous orthodontic treatment?	☐ Yes	☐ No	Explain: _____
Are you satisfied with prior treatment?	☐ Yes	☐ No	With whom? _____
Is there a history of thumb sucking?	☐ Yes	☐ No	Explain: _____

Please check if there is a history of:

☐ Clenching teeth ☐ Muscular soreness around head and neck ☐ Jaw joint soreness ☐ Jaw joint popping
☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in ears
☐ Speech problems (if so, what sounds _____) ☐ Mouth breathing: circle awake asleep

Is there any other information that may be helpful? _____

Patientôs Signature _____ Date _____