ADULT

Name:_____

Williams ORTHODONTICS
Your smile is our specialty

Medical and Dental History Information

Please circle any of the following which you have had or presently have:

Heart Disease	Growth Disorders	Hormone Replacement-	Epilepsy/Seizures
High Blood Pressure	Sleep Apnea	Therapy	Fainting/Dizzy Spells
Heart Surgery	Asthma	Bisphosphonate-	Hepatitis
Heart Murmur	Blood Disorders	medication	HIV or AIDS
Congenital Heart Problems	Bleeding Disorder/	Bone Disorders	Cold Sores
Artificial Heart Valve	Hemophilia	Diabetes	Allergies to Latex
Rheumatism	Anemia	Thyroid Disorder	Allergies to Metals
Artificial Joint	Osteoporosis	Cancer	Allergies to Plastics
Rheumatic Fever		Stroke	Pain/noise in Jaw Joint

Do you have any disease or condition not listed? If so, please list:_____

Have you taken any medications in the last two years? If so, please list:_____

Are you allergic to any drugs or medications? If so, please list:_____

Please describe your current health: Good ☐ Fair ☐ Poor ☐

Women: Are you pregnant? Yes ☐ No ☐ Do you anticipate becoming pregnant within the next few years? Yes ☐ No ☐

Please indicate your main concerns: _____

Have you ever been treated by an orthodontist or seen an orthodontist for a consultation? _____ Yes ☐ No ☐

If you could change anything about the appearance of your teeth or smile, would you do so? _____ Yes ☐ No ☐
What would you change?_____

What concerns you the most about orthodontic treatment? Appearance of appliances ☐ Cost ☐ Length of time ☐ Discomfort ☐ Results ☐

Have you had any periodontal or gum problems? _____ Yes ☐ No ☐
Are you having any pain or discomfort? _____ Yes ☐ No ☐
Have there been injuries to your face, mouth, or teeth? _____ Yes ☐ No ☐
Have you been informed of missing or extra permanent teeth? _____ Yes ☐ No ☐

Are you aware of doing or been told that you do any of the following?

Clenching your teeth	"Tension" headaches	Popping/clicking jaw joint
Grinding your teeth	Migraine headaches	Mouth breathing
Sore/tired jaw muscles	Difficulty opening widely	Tongue thrust

To the best of my knowledge, these answers are true & correct. I will inform the office with any changes in health/medication.

Patient Signature:_____ **Date:** _____