

ADULT HISTORY FORM



wisanu charoenkul, dds ms
14810 Lake Hills Boulevard • Bellevue • WA • 98007
425.747.9210 www.lakehillsortho.com

Patient Name: _____ Date: _____

Any information you can give us about your concerns is appreciated. If unsure, leave blank.

The more we know about each patient, the more personalized we can be in managing your orthodontic treatment.

Dental History

Name of your dentist: _____ Date of last visit: _____

Is there any dental work that you know needs to be done? Yes No What? _____

How many times per day do you brush? _____ Do you floss regularly? _____

Are you experiencing any pain in your mouth at this time? Yes No Describe: _____

Are any of your teeth sensitive to hot or cold? Yes No Describe: _____

Do you have any loose or wiggly teeth? Yes No Describe: _____

Have you had previous periodontal (gum) treatment? Yes No Describe: _____

Do you have any teeth that irritate tongue, cheek, lip, etc.? Yes No Describe: _____

Have any permanent teeth ever been injured by a fall or trauma? Yes No Describe: _____

Have you ever had a severe injury to your upper or lower jaw? Yes No Describe: _____

Are concerned about unusually bad breath? Yes No Describe: _____

Do you snore? If yes, Does it annoy anyone? Yes No Who: _____

Do you know if you clench or grind your teeth? Yes No Describe: _____

Have you ever experienced any pain or tenderness of your jaw joint? Yes No Describe: _____

Do you wear/have a nightguard to protect your teeth from grinding? Yes No Describe: _____

Do you (ever) notice clicking or popping in your jaw joint? Yes, constantly Yes, every once in a while No

Do you have difficulty chewing or opening your mouth? Yes, constantly Yes, every once in a while No

Please elaborate on any other specific dental issues you may be experiencing:

Medical History

Name of physician: _____ Date of last visit: _____

Are you currently being treated for any on-going illnesses? _____

Please describe your overall health: Excellent Good Fair Poor

Please list any medications that you take on a regular basis: _____

Have you ever taken any osteoporosis medicines?(i.e. fosamax, bisphosphonates) Yes No Describe: _____

Are you pregnant? Yes No Do you think you might want to have a child during orthodontic treatment? _____

Do you smoke? Yes, everyday Yes, socially No How many packs per week? _____

Please check any that apply:

<input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Allergies _____	Allergy/Adverse Reaction to:
<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Latex
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Sulfa Drugs
<input type="checkbox"/> Eating Disorders/Bulemia	<input type="checkbox"/> Epilepsy-Seizures	<input type="checkbox"/> Codeine
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Nickel or metals
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Novocain/Xylocaine
<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Iodine
<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> General Anesthesia
<input type="checkbox"/> Bronchitis/Tuberculosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other
<input type="checkbox"/> Arthritis/Rheumatoid Arthritis	<input type="checkbox"/> Endocrine Disorders	

Please also fill out the back of this form

Motivation For Orthodontic Treatment

What initiated your interest in pursuing orthodontic treatment?

- Dentist Recommendation
 Comments from family/friends
 Appearance
 Prevention of future problems
 Pain
 Second opinion
 Improving remaining dental work
 Other _____

How familiar are you with orthodontic treatment?

- I have had braces before
 Another family member has had treatment
 Not very
 I am somewhat familiar
 I have seen an orthodontist before. When? _____

What aspects of treatment worry you?

- Extractions
 Surgery
 Length of treatment time
 Pain/Discomfort
 Appointment times/Missing work or school

How do you feel about wearing braces?

- I am okay with it
 I want braces that show the least
 I absolutely don't want braces that show

I am interested in: metal braces clear braces Invisalign lingual braces Retainers

I am interested in: Ideal treatment (with or without surgery) Best treatment without surgery

What are your goals for your orthodontic treatment?

- Prevent future dental problems
 Improve self-image
 Easier to clean
 Improve smile esthetics
 Alleviate discomfort
 Fix existing problems

Patients and their general dentists often request changes in bites or faces and relief from pain or discomfort.

Please help us to understand your known concerns by checking the following information; please be specific. If unsure, leave blank.

Teeth - If your teeth could be changed, how would you like them to change?

<input type="checkbox"/> Straighten the front teeth --- <input type="checkbox"/> upper <input type="checkbox"/> lower	<input type="checkbox"/> Fillings on teeth --- <input type="checkbox"/> don't like appearance <input type="checkbox"/> don't like color
<input type="checkbox"/> Length of the front teeth --- <input type="checkbox"/> too long <input type="checkbox"/> too short	<input type="checkbox"/> Eliminate spaces between teeth --- <input type="checkbox"/> upper <input type="checkbox"/> lower
<input type="checkbox"/> Shape of the front teeth --- <input type="checkbox"/> too narrow <input type="checkbox"/> too wide	<input type="checkbox"/> Make the line of upper teeth more level
<input type="checkbox"/> Color of front teeth --- <input type="checkbox"/> whiten <input type="checkbox"/> make more even	<input type="checkbox"/> Other

Face - If your facial appearance could be changed, what would you change?

<input type="checkbox"/> Move upper lip --- <input type="checkbox"/> forward <input type="checkbox"/> backward	<input type="checkbox"/> Make profile of nose --- <input type="checkbox"/> longer <input type="checkbox"/> shorter
<input type="checkbox"/> Move lower lip --- <input type="checkbox"/> forward <input type="checkbox"/> backward	<input type="checkbox"/> Get rid of sag under lower jaw
<input type="checkbox"/> Show --- <input type="checkbox"/> more <input type="checkbox"/> less --- of teeth when smiling	<input type="checkbox"/> Move chin --- <input type="checkbox"/> forward <input type="checkbox"/> backward
<input type="checkbox"/> Show --- <input type="checkbox"/> more <input type="checkbox"/> less --- of gums when smiling	<input type="checkbox"/> Move chin --- <input type="checkbox"/> left <input type="checkbox"/> right
<input type="checkbox"/> Reduce the strain in --- <input type="checkbox"/> chin <input type="checkbox"/> lips --- when lips close	<input type="checkbox"/> Other
<input type="checkbox"/> Make lips --- <input type="checkbox"/> closer together <input type="checkbox"/> farther apart --- when teeth are touching	

Symptoms - If you want to reduce pain or discomfort, please be specific about its location; circle the right or left side or both if they apply.

<input type="checkbox"/> My jaw joints --- <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Temples --- <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> In front of ears --- <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> My teeth	<input type="checkbox"/> Eyes --- <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Below ears --- <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> Sinuses	<input type="checkbox"/> Neck --- <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Above ears --- <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> Other	<input type="checkbox"/> Shoulders --- <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> In ears --- <input type="checkbox"/> right <input type="checkbox"/> left

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

Signature of patient or guardian

Date:

For Completion by the dentist.

Dental Management considerations: _____

Signature of Dentist

Date