DR. DANIEL M. T. MA INC.
MEDICAL/DENTAL HISTORY QUESTIONNAIRE – ADULT (age 19 or older)

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential.

Medical History

Have you experienced any health problems? ☐No☐Yes Explain:_____
Any major change in your health recently? ☐No☐Yes Explain:_____
Are you currently under physician's care? ☐No☐Yes Explain:_____
Are you currently taking medications? ☐No☐Yes List : _____
Are you allergic to any medications ? ☐No☐Yes List : _____
Have you received a blood transfusion ? ☐No☐Yes Reason: _____
Have your tonsils or adenoids been removed? ☐No☐Yes When : _____
Are you in a high risk group for AIDS or have you ever tested positive for HIV? ☐No☐Yes Explain : _____

Do you have or have you ever had any of the following conditions?

Heart Murmur……..….	☐No	☐Yes	Hepatitis…….	☐No	☐Yes	Emotional Problems ……	☐No	☐Yes
Heart Surgery.....	☐No	☐Yes	Diabetes…….	☐No	☐Yes	Frequent Headaches ….....	☐No	☐Yes
Rheumatic Fever ……	☐No	☐Yes	Kidney Disease ….	☐No	☐Yes	Nervous/Anxiousness ….	☐No	☐Yes
Endocrine Disorders ….	☐No	☐Yes	Liver Disease	☐No	☐Yes	Cancer	☐No	☐Yes
Prolonged Bleeding ……	☐No	☐Yes	Tuberculosis	☐No	☐Yes	Bone Disorders	☐No	☐Yes
Anemia	☐No	☐Yes	Bronchitis	☐No	☐Yes	Growth Disorders	☐No	☐Yes
Blood Disease	☐No	☐Yes	Asthma	☐No	☐Yes	Mouth Breather	☐No	☐Yes
Developmental Disorder	☐No	☐Yes	Epilepsy	☐No	☐Yes	Herpes (Fever Blisters)	☐No	☐Yes
Hives/Rash	☐No	☐Yes	Fainting	☐No	☐Yes	Tonsillitis	☐No	☐Yes

Is there any other condition or problem that you think we should know about? _____
_____
_____
_____

Dental History

Frequency of dental check ups : Twice a year☐ Once a year☐ Only if a problem exists☐ Never☐ Date of last Visit_____
Is there any unfinished care to be completed with your dentist? ☐No ☐Yes Explain: _____
Are you frightened about dental treatment ? ☐No ☐Yes Explain: _____
Have you had an unpleasant experience in a dental office? ☐No ☐Yes Explain: _____
Have you had any facial or dental injuries? ☐No ☐Yes Explain: _____
Do you play any musical instruments? ☐No ☐Yes What instrument? _____
Have you had an orthodontic consultation before? ☐No ☐Yes With whom ? _____
Have any permanent teeth been removed? ☐No ☐Yes Explain: _____
Have you had any previous orthodontic treatment? ☐No ☐Yes With whom ? _____
Are you satisfied with prior treatment? ☐No ☐Yes Explain: _____
Have you noticed any changes in your bite or dental alignment lately? ☐No ☐Yes Explain: _____

What are the chief concerns you have related to the position of your teeth or bite?

☐ Appearance ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability ☐ Function

Please elaborate: _____

What concerns have your dentist(s) expressed regarding your bite or dental alignment?

☐ Wear or fracture of teeth ☐ Difficulty with cleaning related to alignment of teeth ☐ Bone or gum tissue loss
☐ Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)
☐ Other Please elaborate: _____

Is there any other information that may be helpful? _____
_____

_____ _____ _____
Patient's Signature Date Reviewed By