EDWARD J. SHAHEEN, JR., D.D.S., M.S.

Shaheen Orthodontics, Inc.

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Ladue, MO 63124
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MEDICAL DENTAL HISTORY FORM - ADULT

Date _____

Patient Name Age _____ Birthdate / / Sex _____

Res. Address City St. _____ Zip Telephone _____

Occupation Employed By

Bus. Address City St. _____ Zip Telephone

Spouse's Name

Occupation Employed By

Bus. Address City St. _____ Zip Telephone

Person Responsible for this account Soc. Sec. # _____

Address if different from above _____

Referred by

Name of Dentist

Address Phone No. _____

Name of Physician(s)

Address _____ Phone No.

Other family members treated _____

Orthodontics Insurance coverage yes ____ no

Primary Insurance Co. Policy No.

Secondary Insurance Co. Policy No.

In case we cannot reach you:

Person to contact Phone No.

Present Weight _____ Height Musical Instrument Played

Favorite Sports, Hobbies & Avocations _____

If credit arrangements are requested, a credit check may be necessary.

For the following questions circle **yes, no, 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 Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Stomach ulcer or hyperactivity?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u AIDS or HIV positive?
yes no dk/u Sexually transmitted disease?
yes no dk/u Fainting spells, seizures, epilepsy or neurologic problem?
yes no dk/u Mental health or behavioral problems?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/u Easily tired?

yes no dk/u Chest pain, shortness of breath or swelling ankles?

yes no dk/u **Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?**

yes no dk/u Skin disorder?

yes no dk/u Do you have a normal and good diet?

yes no dk/u Frequent headaches, colds or sore throat?

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 Do you currently have or ever had a substance abuse problem?

yes no dk/u Operations?

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 _____

yes no dk/u Are you in good health? Date of most recent 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 Chipped or otherwise injured permanent teeth?

yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?

yes no dk/u Jaw fractures, cysts, mouth infections?

yes no dk/u "Dead Teeth', root canals treated?

yes no dk/u Bleeding gums, bad taste, mouth odor?

yes no dk/u Periodontal "Gum Problems"?

yes no dk/u Food impaction between teeth?

yes no dk/u "Gum Boils", frequent canker sores, cold sores?

yes no dk/u Thumb, finger, sucking habit? Until _____

yes no dk/u Abnormal swallowing habit (tongue thrushing)?

yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?

yes no dk/u Tooth grinding, jaw clenching, clicking, locking?

yes no dk/u Do you experience any pain or soreness in the muscles of your face, or around the ears?

yes no dk/u Any pain in jaw or ringing in the ears?

yes no dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)

yes no dk/u Difficulty encountered in chewing or jaw opening?

yes no dk/u History of supernumerary (extra) or congenitally missing teeth?

yes no dk/u Have any permanent teeth been removed?

yes no dk/u Aware of loose, broken or missing restorations (fillings)?

yes no dk/u Any teeth irritating cheek, lip, tongue, palate?

yes no dk/u Have you ever had Orthodontic treatment or worn a "retainer" or "bite plate"?

yes no dk/u Have you recently been under another dentist's care?

Specialist _____

yes no dk/u Have you ever had Periodontal (gum) treatment?

yes no dk/u Concerned about spaced, crooked, protruding teeth?

yes no dk/u Aware or concerned about under or over developed jaw?

yes no dk/u Any relative with similar tooth or jaw relationships?

yes no dk/u Any wisdom tooth problems?

yes no dk/u Have you had any serious trouble associated with any previous dental treatment?

What is your primary concern? - Why are you here? _____

_____

_____

_____

Date of most recent dental examination _____

How often does patient brush _____ floss _____

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 treatment?

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her 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 Date

Medical History Update or Changes: Date: Comments: Signature:

_____

_____

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