



## ADULT HEALTH HISTORY

DATE \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS (residence) \_\_\_\_\_  
(Street) (City) (Zip Code)

ADDRESS (employment) \_\_\_\_\_  
(Street) (City) (Zip Code)

HOME PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

DENTIST \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

REFERRED BY \_\_\_\_\_ INSURANCE CO \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

1. Are you in good health?..... YES NO
2. Are you currently under any medical treatment?..... YES NO  
If yes, please explain \_\_\_\_\_
3. Are you currently taking any drugs or medication?..... YES NO  
If yes, please list them \_\_\_\_\_
4. Have you had any adverse or allergic reaction to any drug?.....YES NO  
If yes, describe reaction and name drug \_\_\_\_\_  
\_\_\_\_\_
5. Do you or have you had any cardiovascular related diseases such as  
rheumatic fever, heart murmur, heart attack, high or low blood pressure  
or any other disorder of the heart or blood vessels?.....YES NO  
If yes, please explain \_\_\_\_\_
6. Do you suffer from any respiratory problems such as asthma,  
emphysema, shortness of breath, allergy or tuberculosis?..... YES NO  
If yes, please explain \_\_\_\_\_
7. Do you have any blood disorders such as sugar diabetes, anemia,  
hemophilia or a prothrombln deficiency.....YES NO  
If yes, please explain \_\_\_\_\_
8. Do you exhibit any eye, ear, nose or throat disorder?..... YES NO
9. Have you ever had hepatitis or mononucleosis?..... YES NO

10. Have you received advice or treatment for epilepsy, fainting, convulsions, frequent headaches or dizziness?..... YES NO
11. Have you suffered from recurrent indigestion, jaundice, colitis, ulcers or any other disorder of the stomach, intestines, kidneys, liver or gall bladder?..... YES NO  
If yes, please explain\_\_\_\_\_
12. Have your tonsils or adenoids been removed?..... YES NO
13. Are there any of the following habits: thumbsucking, finger-sucking, lipsucking, nail/lip biting, other?..... YES NO  
If other, please explain\_\_\_\_\_
14. Do you grind or clench the jaw at night?..... YES NO  
During the day?..... YES NO
15. Do you breathe mainly through the mouth at night?..... YES NO  
During the day?..... YES NO
16. Is there any clicking or popping of the jaw at night?..... YES NO
17. Does any member of the family or close relative have a similar arrangement of teeth or appearance of jaws?..... YES NO
18. Have you ever had any periodontal problems (gum treatment)?..... YES NO
19. What is your attitude toward wearing orthodontic appliances?  
Eagerness\_\_\_Willingness\_\_\_Complacency\_\_\_Resignation\_\_\_  
Antagonism\_\_\_Other\_\_\_\_\_
20. Why are you seeking treatment? Appearance\_\_\_Better Chewing\_\_\_  
Better Speech\_\_\_Advice of a Dentist\_\_\_Advice of Friends\_\_\_Other\_\_\_  
Please explain (other)\_\_\_\_\_
21. Are there any other problems associated with your health that have not been covered on this medical history?..... YES NO  
If yes, please explain\_\_\_\_\_

I, \_\_\_\_\_ Individually represent that all statements answers contained herein and in any medical history made a part hereof, are to the best of my knowledge and belief, complete, true and correctly recorded and it is agreed that Dr. DiFranco and his staff et. al. shall not be presumed to have knowledge of any information not so recorded.

DATE\_\_\_\_\_

PATIENT\_\_\_\_\_