MEDICAL & DENTAL HISTORY QUESTIONNAIRE – ADULT

PATIENT NAME: ____DATE OF BIRTH: _________________

Address:____Postal Code:____________________

Employer/ Occupation:____

Phone:____________________Cell:______________________Work:__________________________________

Name of physician: ___________________________________Phone:__________________________________

Name of dentist: ______________________________________Date of last exam: _________________________

1. **Why are you seeking an orthodontic consultation/ what don't you like about your teeth or bite?**
   ____
2. Have you consulted an orthodontist previously? Yes No Dr. __________________
3. Do you have any health problems? Yes No
   If yes, explain:____
4. Have you ever had any serious head or face injuries?
   If yes, explain: ____
5. Do you have any allergies? Yes No
   If yes, please list what you are allergic to: ____
6. List current medications: ____
7. Have you ever been treated for:

a.	Arthritis	Yes	No	j.	Tonsil/adenoid problems	Yes	No
b.	Heart murmur	Yes	No	k.	Sleep apnea/snoring	Yes	No
c.	Heart disease	Yes	No	l.	Seizures	Yes	No
d.	Clenching/grinding	Yes	No	m.	Asthma	Yes	No
e.	Anemia	Yes	No	n.	Cleft lip/palate	Yes	No
f.	Hormone problems	Yes	No	o.	Skin problems	Yes	No
g.	Diabetes	Yes	No	p.	Cold sores	Yes	No
h.	Tuberculosis	Yes	No	q.	Osteoporosis	Yes	No
i.	Cancer	Yes	No	r.	Growth problems	Yes	No

8. Do you wear a nightguard? Yes No
9. Do you have a history of thumb/fingersucking? Yes No
10. Are you a mouthbreather? Yes No

If you have dental insurance, please present your insurance information to the receptionist when you arrive.

Signature: ____DATE:______________________________

Please email completed form toburnaby@nu-smile.ca (Burnaby location) or terrace@nu-smile.ca (Terrace location).