

NEWPORT CENTER

ORTHOTROPICS & ORTHODONTICS

*Making a Difference in Children & Adult's Lives
With Facial Development & Airway Enhancement!*

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Orthotropic & Orthodontic Specialist

Medical Dental History Form for Adult Patients

PATIENT

Date _____
Patient's last name _____ First name _____ Middle initial _____
Title Mr. Mrs. Ms. Miss. Dr. Other _____ I prefer to be called _____
Birth date _____ Sex Male Female Social Security # _____
Marital Status Single Married Separated Divorced Widowed
Home address _____ City, State, Zip code _____
Home phone () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____
Email Address(es) _____
Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relatives name(s) _____
Title Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to patient _____
Address (if different than patient address) _____
Home Phone (if different) () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____

DENTIST

Patient's Dentist _____ Address, City, State _____
Last seen _____ Reason _____ Next appointment _____
Other dentists/dental specialists now being seen: Name _____ City, State _____
Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____
Last seen _____ Reason _____ Next appointment _____
Most recent physical exam _____
Other physicians/health care providers being seen now:
Name _____ City, State _____
Reason _____
Name _____ City, State _____
Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____
Who suggested that you might need orthodontic treatment? _____
Why did you select our office? _____
Have you had any previous orthodontic treatment? Please describe. _____
Have any other family members been treated in this office? Please name them. _____
Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____
Address (if different than page 1) _____ City, State, Zip _____
Home phone () _____ - _____ Cell phone () _____ - _____ Email address(es) _____
Social Security # _____ Employer _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____
Social Security # _____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? Yes No Don't Know

Secondary policy holder's full name _____ Birth date _____
Social Security # _____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? Yes No Don't Know

MEDICAL INSURANCE

Policy holder's full name _____
Insurance Company _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.
 For the following questions, please mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

Yes No DK/U

- Birth defects or hereditary problems?
- Bone fractures or major injuries?
- Any injuries to face, head, neck?
- Arthritis or joint problems?
- Endocrine or thyroid problems?
- Diabetes or low sugar?
- Kidney problems?
- Cancer, tumor, radiation treatment or chemotherapy?
- Stomach ulcer, hyperacidity, acid reflux?
- Immune system problems?
- History of osteoporosis?
- Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- AIDS or HIV positive?
- Hepatitis, jaundice, or other liver problems?
- Polio, mononucleosis, tuberculosis, pneumonia?
- Seizures, fainting spells, neurologic problems?
- Mental health disturbance or depression?
- Vision, hearing, or speech problems?
- History of eating disorder (anorexia, bulimia)?
- High or low blood pressure?
- Excessive bleeding or bruising, anemia?
- Chest pain, shortness of breath, tire easily, swollen ankles?
- Heart defects, heart murmur, rheumatic heart disease?
- Angina, arteriosclerosis, stroke or heart attack?
- Skin disorder (other than common acne)?
- Do you eat a well-balanced diet?
- Frequent headaches or migraines?
- Frequent ear infections, colds, throat infections?
- Asthma, sinus problems, hayfever?
- Tonsil or adenoid condition?
- Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following?

Yes No DK/U

- Local anesthetics (novocaine, lidocaine, xylocaine)
- Latex (gloves, balloons)
- Aspirin
- Metals (jewelry, clothing snaps)
- Penicillin
- Other antibiotics
- Ibuprofen (Motrin, Advil)
- Acrylics
- Plant pollens
- Animals
- Foods
- Other substances _____

DENTAL HISTORY

Now or in the past, have you had:

Yes No DK/U

- Permanent or extra (supernumerary) teeth removed?
- Supernumerary (extra) or congenitally missing teeth?
- Chipped or injured primary or permanent teeth?
- Any sensitive or sore teeth?
- Bleeding gums, bad taste or mouth odor?
- Jaw fractures, cysts, infections?
- Any teeth treated with root canals or pulpotomies?
- "Gum boils," frequent canker sores or cold sores?
- History of speech problems or speech therapy?
- Difficulty breathing through nose?
- Food impaction between the teeth?
- Mouth breathing habit or snoring at night?
- Frequent oral habits (sucking finger, chewing pen, etc)?
- Teeth causing irritation to lip, cheek or gums?
- Abnormal swallowing (tongue thrust)?
- Tooth grinding or clenching?
- Clicking, locking in jaw joints?
- Soreness in jaw muscles or face muscles?
- Ringing in ears, difficulty in chewing or opening jaw?
- Have you ever been treated for "TMJ" or "TMD" problems?
- Any broken or missing fillings?
- Any serious trouble associated with previous dental treatment?
- Have you ever been diagnosed with gum disease or pyorrhea?
- Have you ever had an orthodontic consultation or treatment before now?

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements, that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Do you take antibiotic pre-medication before any dental procedures? _____

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

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

Women: Are you pregnant? Yes No Are you trying to become pregnant? Yes No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain. _____

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Y N

Functional Somatic Syndrome:

- ___ ___ Chronic Fatigue Syndrome_____
- ___ ___ Irritable Bowel Syndrome_____
- ___ ___ Fibromyalgia_____
- ___ ___ Polysomatic Disorder_____
- ___ ___ Mood Swings/irritability_____
- ___ ___ Anxiety/Panic Attacks_____

Autonomic Nervous System:

- ___ ___ Hypotension (low blood pressure)_____
- ___ ___ Orthostasis-light headed when standing up_____
- ___ ___ Cold hands and feet_____
- ___ ___ Unexplained shaking at night_____
- ___ ___ History of latent bed wetting_____
- ___ ___ Night sweats_____

Dentition:

- ___ ___ Deep Overbite_____
- ___ ___ Several tooth/restoration fracture history_____
- ___ ___ Mortal-pestal dished out wear pattern 2nd molars_____
- ___ ___ Lower molar cusp lesions / acid erosion_____
- ___ ___ Excessive anterior crowding mand/max teeth_____
- ___ ___ Excessive anterior attrition/wear_____
- ___ ___ c/o sensitivity/pain to percussion anterior teeth_____
- ___ ___ Constricted envelope of function_____
- ___ ___ Accelerated generalized tooth wear_____
- ___ ___ Cervical abfraction lesions/recession_____
- ___ ___ Non-carious sensitivity of teeth_____

Y N

Orthodontic History:

- ___ ___ Retreats/Why_____
- ___ ___ Teeth Extracted?_____
- ___ ___ History of headgear_____
- ___ ___ History of palatal expansion_____
- ___ ___ History of functional appliances_____

Neurologic:

- ___ ___ Balance/Tripping_____
- ___ ___ Constipation_____
- ___ ___ Tingling in hands_____
- ___ ___ Pill rolling_____
- ___ ___ Hand/Arm hanging while walking_____
- ___ ___ Night time drooling_____
- ___ ___ Eczema_____
- ___ ___ OCD (Obsessive Compulsive Disorder)_____
- ___ ___ Ferritin Levels (Menses)_____

- 1. = Baseline**
- 2. = Improvement**

EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never *doze or fall asleep* in a given situation, and 3 meaning there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

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SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

TOTAL SCORE _____

Name: _____

Date: _____

FATIGUE SEVERITY SCALE (FSS)

Date _____ Name _____

Please circle the number between 1 and 7 which you feel best fits the following statements. This refers to your usual way of life within the last week. **1** indicates "strongly disagree" and **7** indicates "strongly agree."

Read and circle a number.	← Strongly Disagree	Strongly Agree →
1. My motivation is lower when I am fatigued.	1	2 3 4 5 6 7
2. Exercise brings on my fatigue.	1	2 3 4 5 6 7
3. I am easily fatigued.	1	2 3 4 5 6 7
4. Fatigue interferes with my physical functioning.	1	2 3 4 5 6 7
5. Fatigue causes frequent problems for me.	1	2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning.	1	2 3 4 5 6 7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2 3 4 5 6 7
8. Fatigue is among my most disabling symptoms.	1	2 3 4 5 6 7
9. Fatigue interferes with my work, family, or social life.	1	2 3 4 5 6 7

VISUAL ANALOGUE FATIGUE SCALE (VAFS)

Please mark an "X" on the number line which describes your global fatigue with 0 being worst and 10 being normal.

0	1	2	3	4	5	6	7	8	9	10