

ADULT

Please Answer All Questions

Date _____

(Circle yes or no and print in blanks where required)

Name _____

I. MEDICAL HISTORY

Date of last Medical examination _____ By whom? _____

1. Are you in general good health at this time? Yes No

2. Have you been under the care of a physician during the past two years (other than routine checks)? Yes No

Reason _____

3. Are you receiving any medicine or pills now? Yes No

If so, list _____

4. Have you ever had any surgery? Yes No

For what conditions _____

5. The following diseases are of interest to Dr. Kottemann. Please check any that you have had:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies, list _____ | <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Prolonged bleeding |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatism or arthritis |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Immune system disorders |
| <input type="checkbox"/> Colds (frequent) | <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Sore throat (frequent) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach or intestinal disease |
| <input type="checkbox"/> Ear infection (frequent) | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emotional disorders | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tumors or growths |

6. Do you have any special conditions not listed above? Yes No

Explain _____

7. Have you ever had a serious accident involving head injuries? Yes No

8. Have you ever had an unusual reaction to any drug such as penicillin or local anesthetic? What? _____ Yes No

9. Have you ever experienced any complications to healing? Yes No

10. Have you ever had any X-ray treatments (other than diagnostic)? Yes No

11. Have your tonsils and/or adenoids been removed? Yes No

12. Are you on any kind of special diet? Yes No

13. Do you wear contact lenses? Yes No

14. Females: Are you pregnant? Yes No

II. DENTAL HISTORY

Date of last dental examination _____ By whom? _____ Is work done? _____

Date of last full-mouth X-ray _____ Where? _____

1. Are you concerned about the appearance of your teeth? Yes No
2. Have you ever been teased about the appearance of your teeth? Yes No
3. Has orthodontic treatment been suggested in the past? Yes No
4. Who first noticed the need for orthodontic treatment? Circle one: Dentist You
5. Have you had previous orthodontic consultations and/or treatment? Where _____ Yes No
6. Has any member of the family had orthodontic treatment? Where? _____ Yes No
7. Do you have concerns about orthodontic treatment, or wearing braces or headgear? Yes No
8. Are you willing to give maximum cooperation for approximately two years? Yes No
9. Are you aware that some appointments will infringe on your normal business hours? Yes No
10. How many times a year has your dentist examined your teeth? _____
11. Have you had any serious trouble with any previous dental treatment? Yes No
If so, explain _____
12. Are you having any discomfort or pain? Yes No
13. Are there now any unhealed injuries or inflamed areas in or around your mouth? Yes No
14. Do you now have any growths or sore spots in your mouth? Yes No
15. Do you have any problems with sore and/or bleeding gums? Yes No
16. Is any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? Yes No
If so, locate _____
17. Have you ever had a jaw or mouth injury? Explain _____ Yes No
18. Have there ever been any injuries to your teeth? Explain _____ Yes No
19. Have you ever had pains in the face or head **other** than a toothache? Yes No
20. Have you ever had pain in or near the ear? Yes No
21. Do you play a musical instrument? What? _____ Yes No
22. Do you have any of the following habits?
 Nail Biting Tongue thrusting
 Grinding of Teeth Mouth breathing
 Other _____
23. Compare decay amount or experience with others in your family: _____

24. How many times a day do you brush your teeth? _____
25. Do you use dental floss? Yes No
26. Have you ever been instructed in proper toothbrushing technique? Yes No

Please make any other comments that you feel may be helpful _____

