Orthodontic Specialists of Madison

New Adult Patient Questionnaire

Today's Date: _____

Name: _____ Date of Birth: _____

Nickname: _____ Gender: ○ Male ○ Female

Employer: _____ Occupation: _____

Whom may we thank for referring you? _____

General Dentist: _____ Date of Last Visit: _____

Do you have a personal physician? ○ *Yes* ○ *No* Physician's Name: _____

Are you taking any prescription drugs? ○ *Yes* ○ *No* Women: Are you pregnant? ○ *Yes* ○ *No*

List each medicine being taken: _____

Have you ever had any of the following medical conditions?

Arthritis	○ *Yes*	○ *No*	Hepatitis	○ *Yes*	○ *No*
Artificial Bones/Joints	○ *Yes*	○ *No*	High/Low Blood Pressure	○ *Yes*	○ *No*
Artificial Heart Valve/Pacemaker	○ *Yes*	○ *No*	HIV/AIDS	○ *Yes*	○ *No*
Asthma	○ *Yes*	○ *No*	Jaw Clicking/Popping	○ *Yes*	○ *No*
Cancer/Chemotherapy	○ *Yes*	○ *No*	Kidney Problems	○ *Yes*	○ *No*
Diabetes	○ *Yes*	○ *No*	Mitral Valve Prolapse	○ *Yes*	○ *No*
Difficulty Breathing	○ *Yes*	○ *No*	Rheumatic/Scarlet Fever	○ *Yes*	○ *No*
Emotional Problems	○ *Yes*	○ *No*	Severe/Frequent Headaches	○ *Yes*	○ *No*
Epilepsy/Seizures/Fainting Spells	○ *Yes*	○ *No*	Sleep Disorders	○ *Yes*	○ *No*
Genetic Disorders	○ *Yes*	○ *No*	TMJ (Jaw Joint) Soreness	○ *Yes*	○ *No*
Glandular Disorders	○ *Yes*	○ *No*	TMJ (Jaw Joint) Stiffness	○ *Yes*	○ *No*
Heart Attack/Stroke	○ *Yes*	○ *No*	Tonsils/Adenoids Removed	○ *Yes*	○ *No*
Heart Murmur	○ *Yes*	○ *No*	Tuberculosis	○ *Yes*	○ *No*
Hemophilia/Abnormal Bleeding	○ *Yes*	○ *No*	Other		

Are you allergic to latex?	○ *Yes*	○ *No*	Are you allergic to nickel?	○ *Yes*	○ *No*
Have you ever been told by a physician that you need to take premedication prior to dental procedures?	○ *Yes*	○ *No*	Have you ever taken diet medications?	○ *Yes*	○ *No*

Please use the space below to describe any significant medical problems/procedures that you have had:

What is your main reason for seeking this orthodontic consultation?

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Thank you for taking the time to complete this form. It will help us serve you better.