

Jeffrey W. Vecere, D.M.D., M.S.D., P.A.

22 West Pacific Avenue – Cape May Court House, NJ 08210

N.J. Specialty Permit No. 3226

MEDICAL HEALTH HISTORY ADULT

Patient Name: _____ I prefer to be called: _____

Please check any of the following conditions which you may have or have had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Phobias | <input type="checkbox"/> Herpes or Cold Sores |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Prolonged Infection | <input type="checkbox"/> Bone Disorders |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Prolonged Sickness | <input type="checkbox"/> Tumors and Growths |
| <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Wear a Pacemaker | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Frequent Indigestion |
| <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Soreness/Swelling Under Jaw, Arms, etc. |
| <input type="checkbox"/> Tonsilitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> History of eating disorder? (anorexia or bulimia) |
| <input type="checkbox"/> Osteoporosis? | <input type="checkbox"/> Asthma | |

Date of Last Medical Examination _____

Family Physician _____

Please answer YES or NO to the following questions:

Are you presently under a physician's care? Yes No

If YES, for what condition? _____

Are you pregnant? Yes No

Do you need antibiotic medication before you see your dentist? Yes No

Are you presently receiving any medication? Yes No

Have you ever had an unusual reaction to any drug such as penicillin or local anesthetics? Yes No

Have you been absent from work more than 5 days last year? Yes No

Have your tonsils or adenoids been removed? Yes No

Have you had major surgery? Yes No

If YES, for what condition? _____

Are there any other pertinent medical problems? Yes No

If YES, please describe _____

Please complete second side of form »

PATIENT DENTAL HISTORY

Date of last dental examination? _____

Have you received a severe blow to the teeth or jaws? Yes No

Do you have problems with sore or bleeding gums? Yes No

Do you brush your teeth conscientiously? Yes No

Do you have any of the following habits?

Thumb Sucking Nail Biting Snoring Mouth Breathing

Grinds teeth during night or day Clenches teeth during night or day

Have you ever had speech therapy? Yes No

Who first noticed the need for orthodontic treatment? _____

Do you want your teeth straightened? Yes No

Please offer other comments that may be helpful _____

Have you ever been treated for "TMJ/TMD" problems? Yes No

Have you ever had accident or trauma: To the head? To the neck? To the face?

Have you had headaches in the temple area? Yes No Left _____ Right _____

Have you experienced sinus problems? Yes No Left _____ Right _____

Have you experienced a popping clicking and/or
grating noise in the ears? Yes No Left _____ Right _____

Have you experienced chronic stiff neck? Yes No Left _____ Right _____

Difficulty in chewing or jaw opening? Yes No Left _____ Right _____

Aware of loose, broken or missing
restorations (fillings)? Yes No Left _____ Right _____

Any teeth irritating cheek, lip,
tongue or palate? Yes No Left _____ Right _____

Had periodontal (gum) treatment?

Had any serious trouble associated with
any previous dental treatment? Yes No Left _____ Right _____

Been under another dentist's care?

 Specialist _____

 Other _____

Ever had a prior orthodontic examination
or treatment? Yes No

Signature of Patient _____ Date _____

Orthodontist _____ Date _____