

Cooper Orthodontics

Joel D. Cooper, DDS, MS

Adult Health History: Please complete the following:

Your current physical health is: ___ Good ___ Fair ___ Poor

Are you currently under the care of a physician? ___ Yes ___ No

Please explain: _____

Are you taking any prescription/over the counter drugs? ___ Yes ___ No

Please list each one: _____

FOR WOMEN: Are you taking birth control pills? ___ Yes ___ No

Are you pregnant: ___ Yes ___ No Week#: _____

Are you nursing: ___ Yes ___ No

Have you ever had any of the following diseases or medical problems?

- | | |
|---|--|
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Abnormal Bleeding | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Heart Surgery/Pacemaker |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Anemia/Radiation Treatment | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Hemophilia |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Artificial Bones/Joints/Values | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Hepatitis |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Asthma/Arthritis | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N High/Low Blood Pressure |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Blood Transfusion | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N HIV/AIDS |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Cancer/Chemotherapy | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Hospitalized for any Reason |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Congenital Heart Defect | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Kidney Problems |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Diabetes/Tuberculosis | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Mitral Valve Prolapse |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Difficulty Breathing | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Psychiatric Problems |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Drug/Alcohol Abuse | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Rheumatic/Scarlet Fever |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Emphysema/Glaucoma | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Severe/Frequent Headaches |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Epilepsy/Seizures/Fainting | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Shingles |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Fever Blisters/Herpes | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Sinus Problems |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Heart Attack/Stroke | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Ulcers/Colitis |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Heart Murmur | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N aspirin | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Dental anesthetics | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Penicillin |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N any metals/plastics | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Erythromycin | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Tetracycline |
| <input type="checkbox"/> _Y_ <input type="checkbox"/> _N codeine | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N Latex | <input type="checkbox"/> _Y_ <input type="checkbox"/> _N OTHER |

Please list any other drugs/materials that you are allergic to: _____

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever had or been evaluated for orthodontic treatment? ___Y___N

Have you ever had a serious/difficult problem associated with any previous dental work? ___Y___N

Do you now or have you ever experienced pain/discomfort in your jaw joint(TMJ)? ___Y___N

Your current health is ___ Good ___ Fair ___ Poor

Do you like your smile? ___Y___N

Have you ever had an injury to your: ___ Mouth ___ Teeth ___ Chin

Do you have speech problems? ___Y___N

Do you generally breathe through your mouth? ___Y___N

Do you have any missing or extra permanent teeth? ___Y___N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize **Cooper Orthodontics** to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE

DATE