Date _____

Name _____

Birthdate _____

Social Security # _____

Height _____ Weight _____ Occupation _____

ROGERS, DUNCAN & DILLEHAY
SPECIALIST IN ORTHODONTICS
J. Kendall Dillehay, DDS, MS

Adult Medical History

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health?	Yes	No
Has there been any change in your general health within the past year?	Yes	No
When was your last physical examination? _____		
Are you now under the care of a physician?	Yes	No
If so, what condition are you being treated for? _____		
Your physician's name and address _____		
_____		
Address City/State Zip		
Have you ever had any *serious* illness or operation?	Yes	No
If so, what was the illness/operation? _____		
Have you ever had joint replacement surgery?	Yes	No
Have you ever been hospitalized or had a serious illness in the past 5 years?	Yes	No
If so, what was the problem? _____		
Do you have or have you had any of the following diseases/conditions:		
Rheumatic fever/rheumatic heart disease?	Yes	No
Congenital heart lesions?	Yes	No
Cardiovascular diseases (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)?	Yes	No
Pain in the chest upon exertion?	Yes	No
Shortness of breath after mild exercise?	Yes	No
Swelling of the ankles?	Yes	No
Shortness of breath when lying down/ require extra pillows when you sleep?	Yes	No
Do you have a cardiac pacemaker?	Yes	No
Heart valves replaced?	Yes	No
Heart bypass surgery?	Yes	No
Allergies?	Yes	No
Sinus trouble?	Yes	No
Asthma/hay fever?	Yes	No
Hives/skin rash?	Yes	No
Fainting spells/seizures?	Yes	No
Diabetes?	Yes	No
Urinate (pass water) more than 6 times a day?	Yes	No
Thirsty much of the time?	Yes	No
Frequent drymouth?	Yes	No
Hepatitis, jaundice or liver disease?	Yes	No
Arthritis?	Yes	No
Inflammatory rheumatism (painful swollen joints)?	Yes	No
Stomach ulcers?	Yes	No
Kidney trouble?	Yes	No
Tuberculosis?	Yes	No
Do you have a persistent cough/cough up blood?	Yes	No
Low blood pressure?	Yes	No
Venereal disease?	Yes	No
Other _____		

Have you ever had abnormal bleeding associated with previous extraction, surgery, or trauma?	Yes	No
Do you bruise easily?	Yes	No
Have you ever required a blood transfusion?	Yes	No
If so, please explain _____		
Do you have any blood disorder such as anemia?	Yes	No
Have you had surgery /x-ray treatment for a tumor, growth or other condition of your head/neck?	Yes	No
Are you taking any drugs/medication?	Yes	No
If so, please list _____		
Are you taking any of the following:		
Antibiotics/sulfa drugs?	Yes	No
Anticoagulants (blood thinners)?	Yes	No
Medicine for high blood pressure?	Yes	No
Cortisone (steroids)?	Yes	No
Tranquilizers?	Yes	No
Antihistamines?	Yes	No
Aspirin?	Yes	No
Insulin, tolbutamide (Orinase) or similar drug?	Yes	No
Digitalis/drugs for heart trouble?	Yes	No
Nitroglycerin?	Yes	No
Oral contraceptive/other hormonal therapy?	Yes	No
Other _____		
Are you allergic to/have you ever reacted adversely to:		
Local anesthetics?	Yes	No
Penicillin/other antibiotics?	Yes	No
Sulfa drugs?	Yes	No
Barbiturates, sedatives or sleeping pills?	Yes	No
Aspirin?	Yes	No
Iodine?	Yes	No
Codeine/other narcotics?	Yes	No
Other _____		
Have you had any serious trouble associated with any previous dental treatment?	Yes	No
If so, please explain _____		
Do you have any disease, condition or problem not listed above that you think we should know about?	Yes	No
If so, please explain _____		
Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?	Yes	No
Are you wearing contact lenses?	Yes	No
Women:		
Are you pregnant?	Yes	No
Do you have any problem associated with your menstrual period?	Yes	No

Chief Dental Complaint:

_____

Signature of patient

East | 1821 N. Rock Road | Wichita, KS 67206 | *tel* 316.683.6518 | *fax* 316.683.0918 | *toll-free* 1.800.794.1818
West | 9909 W. 21st Street N. | Wichita, KS 67205 | *tel* 316.722.0857 | *web* www.toothmovers.org

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PERSONAL INFORMATION

1821 N. Rock Road / Wichita, Kansas 67206 / (316) 683-6518
9909 W. 21st St. N. / Wichita, Kansas 67205 / (316) 722-0857

DIPLOMATE OF THE AMERICAN BOARD OF ORTHODONTICS

J. KENDALL DILLEHAY, D.D.S.

Patient's Name: _____ Sex _____
Last First Nickname

Home Address _____ Phone _____

Date _____ Age _____ Birthdate _____ School _____

1. Responsible Party _____ Relationship _____
   Address (If different) _____ Phone _____
   Business of Responsible Party _____ Bus. Phone _____
   Insurance Co. _____ SS# _____
   Policy # _____ Birthdate _____
   E-mail _____
2. Responsible party _____ Relationship _____
   Address (If different) _____ Phone _____
   Business of Responsible Party _____ Bus. Phone _____
   Insurance Co. _____ SS# _____
   Policy # _____ Birthdate _____

Other Family Members who have been seen by our Doctors: _____

How did you first hear of our office? _____

General Dentist _____

Patient's favorite hobbies and special interests: _____

The American Association of Orthodontists recommends that a child's first visit to an orthodontist should take place when an orthodontic problem is first detected. Depending on the nature of the problem, whether it's jaw growth problems, tooth problems or both, this first visit could take place as early as age 2 or 3, as the primary teeth erupt. Whether or not an orthodontic problem is detected, however, a child should visit an orthodontist for an evaluation no later than age 7. This may surprise you because orthodontic treatment is usually associated with adolescence. Though treatment does not necessarily begin at this early age, an examination is very important to ensure maximum dental health for your child.

If you would like for us to place the names of your younger children in our file for future examination, please list their names and dates of birth below. We will send you a reminder card shortly after their seventh birthday.

NAME	DATE OF BIRTH