Adult medical history

Personal details

Title

☐ Mr ☐ Dr
☐ Mrs ☐ Mx
☐ Miss ☐ Prof
☐ Ms
☐ Other_____

First name* Middle name

Last name* Date of birth*

Gender* ☐ Male ☐ Female ☐ Non-binary

Address*

Suburb* Postcode*

Home phone Mobile phone

Work phone Email *

Occupation

Preferred contact ☐ Home ☐ Mobile ☐ Work

Emergency Contact

Full name Relationship to patient

Email Contact number

Doctor details

Medical practitioner Family dentist

Referring dentist

Trauma

Have you ever had an accident involving teeth or jaw? * ☐ Yes ☐ No

Have you ever had clicking, noises, or pain in your jaw joints? * ☐ Yes ☐ No

Medical history

This may affect the orthodontic treatment. Please circle the correct answer and provide details when necessary.

Allergy to latex *
☐ Yes ☐ No

Heart or Kidney Disease *
☐ Yes ☐ No

Asperger's, Autism, ADD, ADHD *
☐ Yes ☐ No

Allergies *
☐ Yes ☐ No

Asthma *
☐ Yes ☐ No

Blood pressure *
☐ ☐

Anesthesia complications *
☐ Yes ☐ No

Is there a possibility that you could be pregnant *
☐ Yes ☐ No

Prolonged bleeding after injury *
☐ Yes ☐ No

Serious operation *
☐ Yes ☐ No

Are you taking any medication *
☐ Yes ☐ No

Hepatitis or HIV *
☐ Yes ☐ No

Other *
☐ ☐

Congenital heat disease or rheumatic fever *
☐ Yes ☐ No

Medical history (cont)

Psychiatric or Psychological care *
☐ Yes ☐ No

Do you require antibiotic cover for dental procedures *
☐ Yes ☐ No

Diabetes, Epilepsy, Goitre etc *
☐ Yes ☐ No

Prone to fainting *
☐ Yes ☐ No

Further details, if necessary

Sleep disturbance scale

At Smile Team Orthodontics we believe that all of our clients (both children and adults) should be screened before they consider orthodontic treatment because our treatment recommendations may differ in the presence of sleep apnea.

What is Obstructive Sleep Apnea? Sleep Apnea occurs when the walls to the throat close during sleep, causing breathing to stop. Once the brain registers that it is not breathing, the sleeper usually wakes up, rouses and the throat opens again, then they drift back to sleep. The person effected by sleep apnea, in most cases, does not realise they have even woken. It also causes decreased Oxygen Intake. This means the brain, heart and nervous system are not receiving their required time to rest and oxygenate. The pattern can repeat itself hundreds of times every night. One of the side effects of Sleep Apnea is Cardiac Problems. Also drivers with sleep apnea have 8 times the risk of car accidents.

Sudden Cardiac Death during sleep occurs more commonly in patients who have Obstructive Sleep Apnea.

Epworth Sleepiness Scale – for 17 years and older. Use the following scale to choose the most appropriate for each situation.

Sitting and reading *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Watching TV *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Sitting inactive in a public space *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Being a passenger in a motor vehicle for an hour or more *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Lying down in the afternoon *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Sitting and talking to someone *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Sitting quietly after lunch (no alcohol) *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Stopped for a few minutes in traffic while driving *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Referral

Have you had another member of your family treated in this practice? * ☐ Yes ☐ No

If YES what is the family member's name?

Do you have a referral? * ☐ Yes ☐ No

Have you had a dental check up in the last 12 months? * ☐ Yes ☐ No

How did you hear about Smile Team Orthodontics?*

Please select ONE that may apply and provide details when necessary in box below.

- ☐ Google
- ☐ Family/Referring Dentist
- ☐ TikTok
- ☐ Relative
- ☐ Radio – Power FM Bowral/South Coast
- ☐ Television Ad
- ☐ Radio – 2ST Bowral
- ☐ Instagram
- ☐ Specialist
- ☐ Bus Stop
- ☐ Other
- ☐ Invisalign
- ☐ Facebook
- ☐ Sibling
- ☐ Friend
- ☐ Radio – i98 FM Illawarra
- ☐ Smile Team Website
- ☐ Sign
- ☐ Member of Staff
- ☐ Email
- ☐ Crown Mall Wollongong

If Specialist, please specify

If Friend, please name

If Member of Staff, please specify

If Relative, please name

If Other, please specify

Person responsible for paying for the orthodontic treatment

Name of person paying for treatment - Same as client details *

☐ Yes

☐ No

If NO please enter details below.

Title

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Mx ☐ Prof ☐ Other

First name* Last name*

Address*

Postcode Phone *

Email * Relationship to client

Date

Please sign here