



**Cameron H. George, D.D.S., M.S.**

**Daniel C. George, D.D.S., M.S.**

Diplomate, The American Board of Orthodontics

We are pleased that you called our office for your Orthodontic Evaluation. At this appointment a preliminary evaluation and diagnosis will be made. The visit will take approximately one hour. If orthodontic treatment is indicated, more diagnostic information will be prescribed.

Please complete this questionnaire and bring it to your appointment.

We are looking forward to seeing you on Day \_\_\_\_\_, Date \_\_\_\_\_ Time \_\_\_\_\_ AM. PM.

### Health History Questionnaire

Patient's Name \_\_\_\_\_ Sex: M F Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SS # \_\_\_\_\_

School/Employer \_\_\_\_\_ Department/Grade \_\_\_\_\_

Father/Husband \_\_\_\_\_ Marital Status \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Mother/Wife \_\_\_\_\_ Marital Status \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Names/Ages of other children in family \_\_\_\_\_

Siblings/Friends treated here \_\_\_\_\_

Person responsible for account \_\_\_\_\_ Relationship \_\_\_\_\_

Referred By \_\_\_\_\_

Email Address \_\_\_\_\_

### All insurance information is necessary prior to billing your carrier.

Primary Orthodontic Insurance \_\_\_\_\_ Address \_\_\_\_\_

Insured Employee \_\_\_\_\_ Birthdate \_\_\_\_\_ Group # \_\_\_\_\_ Plan # \_\_\_\_\_

Secondary Orthodontic Insurance \_\_\_\_\_ Address \_\_\_\_\_

Insured Employee \_\_\_\_\_ Birthdate \_\_\_\_\_ Group # \_\_\_\_\_ Plan # \_\_\_\_\_

**Please bring in any insurance cards or information you may have to your next appointment. Thank you. We will bill your insurance company for services rendered. You are responsible for the account in the office, any insurance payments will be sent directly to you.**



# Medical History

Family Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Medical Specialists seen regularly? \_\_\_\_\_ Specialty \_\_\_\_\_

Date of last complete physical \_\_\_\_\_ Examining doctor \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Body Frame Size: Small  Medium  Large

## History of Specific Problems

*EXPLAIN IF YES*

Head/Neck Problems    No  Yes     Headaches  Migraine  Sinus  Eyes  Temples  \_\_\_\_\_  
 Back of Head  Painful Scalp  Neck Pain  \_\_\_\_\_  
 Lumps in Neck  Tired/Sore Neck Muscles  \_\_\_\_\_

Neural Problems    No  Yes     Epilepsy  Seizures  Numbness/Tingling  \_\_\_\_\_  
 Other  \_\_\_\_\_

Eye Problems    No  Yes     Pain  Bloodshot  Blurred Vision  \_\_\_\_\_  
 Pressure on Eyeballs  Light Sensitivity  \_\_\_\_\_  
 Watery  Drooping Eyelids  \_\_\_\_\_

Ear Problems    No  Yes     Pain  Clogged  Hissing  Ringing  Dizziness  \_\_\_\_\_  
 Nausea  Loss of Hearing Volume  Loss of Balance  \_\_\_\_\_

Nose/Sinus Problems    No  Yes     Obstruction  Stiffness  Runny Nose  \_\_\_\_\_

Throat Problems    No  Yes     Sore Throat  Swallowing Difficulties  \_\_\_\_\_  
 Lump in Throat  Laryngitis  Voice Fluctuations  \_\_\_\_\_  
 Tongue Pain  Persistent Coughing/Clearing Throat  \_\_\_\_\_

Breathing Problems    No  Yes     Asthma  Wheezing  Shortness of Breath  \_\_\_\_\_  
 Chronic Cough  Cough Up Blood/Sputum  \_\_\_\_\_

Back, Shoulders, Extremity Problems    No  Yes     Aching Shoulders  Stiffness  Lack of Mobility  \_\_\_\_\_  
 Upper  Lower  Back Pain  Numbness in Arms  \_\_\_\_\_  
 Cramps in Legs: When Walking  At Night  \_\_\_\_\_  
 Arms/Legs Weakness  Leg/Ankle Swelling  Gout  \_\_\_\_\_

Bone Problems    No  Yes     Break Easily  Pain  Arthritis  \_\_\_\_\_  
 Joint Pain  Joint Swelling  \_\_\_\_\_

Heart Problems    No  Yes     Coronary Heart Disease  Heart Valve Disease  \_\_\_\_\_  
 High Blood Pressure  Chest Pain  Angina  \_\_\_\_\_  
 Heart Murmur  Irregular Heartbeat  Palpitations  \_\_\_\_\_

Stomach & Intestine Problems    No  Yes     Ulcers  Bleeding  Abdominal Pain  Heartburn  \_\_\_\_\_  
 Nausea/Vomiting  Constipation  Diarrhea  \_\_\_\_\_  
 Gall Bladder Disease  Intestinal Disease  \_\_\_\_\_  
 Black Stool  Intolerance to: Milk  Eggs  \_\_\_\_\_

Endocrine Problems    No  Yes     Pancreas  Thyroid  Pituitary  \_\_\_\_\_

Liver Problems No  Yes  \_\_\_\_\_  
\_\_\_\_\_

Kidney Problems No  Yes  \_\_\_\_\_  
\_\_\_\_\_

Blood Problems No  Yes  Hemophilia  Anemia  Bruise Easily  HIV Virus (AIDS)   
Bleed Easily  Blood Clots  Stroke  \_\_\_\_\_  
Are you at risk of contacting AIDS (HIV Virus i.e. Blood Transfusions, Hemophilia, other)  \_\_\_\_\_

Chronic Disease No  Yes  Diabetes  Cancer  Hepatitis A  B  Kidney   
Swelling  Tonsillitis  Excessive Colds  Arthritis  \_\_\_\_\_  
Family History of These Diseases? No  Yes  Y \_\_\_\_\_

Heart Problems No  Yes  Heart Valve date \_\_\_\_\_ Pacemaker date \_\_\_\_\_  
Bypass date \_\_\_\_\_ date \_\_\_\_\_  
\_\_\_\_\_

Other Surgery No  Yes  Tonsils date \_\_\_\_\_ Adenoids date \_\_\_\_\_  
\_\_\_\_\_

Serious Injury No  Yes  \_\_\_\_\_  
\_\_\_\_\_

Occupational Disease (ADULTS) No  Yes  \_\_\_\_\_  
\_\_\_\_\_

Habit Excesses No  Yes  Smoking \_\_\_\_\_ packs/day for \_\_\_\_\_ years  
Caffeine  Alcohol  Eating Disorder  \_\_\_\_\_

Exercise Regularly No  Yes  \_\_\_\_\_ Hours/Day  Week  Month  \_\_\_\_\_

Psychological Problems No  Yes  Anxiety  Depression  Psychiatric Disorder   
Insomnia  \_\_\_\_\_

Presently Taking Medications (Dosage?) No  Yes  Birth Control  Diuretics  Blood Pressure   
Blood Thinners  Heart  Tranquilizers  \_\_\_\_\_

Allergic Reactions No  Yes  Hay Fever  To Foods  To Metals/Plastics  \_\_\_\_\_

Drug Reactions No  Yes  Anti-Bacterial Drugs  \_\_\_\_\_

Please indicate anything else we should know about the present state of your health, not mentioned above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Dental History

Family Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

Dental Specialists who have treated you (Give Names, Treatments & Dates): \_\_\_\_\_  
\_\_\_\_\_

How many times per day do you **BRUSH** your teeth? 0  1  2+  How many times per day do you **FLOSS** your teeth? 0  1  2+

## History of Specific Problems

*EXPLAIN IF YES*

Tooth Injury No  Yes  Chipped  Broken  Lost  \_\_\_\_\_

Oral Disease No  Yes  Ulcers  Sores  \_\_\_\_\_

Jaw Joint Pain No  Yes  Right T.M.J.: Constant  Periodic  When You: Chew  Yawn  Talk  Open Wide   
Left T.M.J.: Constant  Periodic  When You: Chew  Yawn  Talk  Open Wide

**Comments:** \_\_\_\_\_  
\_\_\_\_\_

Jaw Joint Noises No  Yes  Right T.M.J.: Click  Popping  Grating   
Left T.M.J.: Click  Popping  Grating  \_\_\_\_\_

Jaw Joint Locking No  Yes  Right T.M.J.: When Open  When Closed   
Left T.M.J.: When Open  When Closed  \_\_\_\_\_

Grinding Your Teeth No  Yes  During the Day  \_\_\_\_\_  
When Sleeping  \_\_\_\_\_

Clenching Your Teeth No  Yes  During the Day  \_\_\_\_\_  
When Sleeping  \_\_\_\_\_

Bleeding Gums No  Yes  Usually  Sometimes  Rarely   
When Brushing  Flossing  Eating  \_\_\_\_\_

Oral Habits No  Yes  Thumb Sucking  Finger Sucking   
Tongue Thrusting  Nail Biting  \_\_\_\_\_

Other Oral Problems No  Yes  If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

Chief Concern Regarding Your Teeth \_\_\_\_\_

Have you ever had:

Periodontal (gums) Treatment No  Yes  Type of treatment + date \_\_\_\_\_

Orthodontic (braces) Treatment No  Yes  Type of treatment + date \_\_\_\_\_

Endodontic (root canal) Treatment No  Yes  Type of treatment + date \_\_\_\_\_

Oral Surgery (jaw surgery) Treatment No  Yes  Type of treatment + date \_\_\_\_\_

Prosthodontic (crown & bridge) Treatment No  Yes  Type of treatment + date \_\_\_\_\_

I hereby certify that I have reviewed the above medical history and that it is accurate to my knowledge at this time. If there are any future changes in this information, I will inform the office.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Treatment Coordinator

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date