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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 _____

Person responsible for account _____ Relationship _____

May we contact you at work? ❑Yes ❑No

May we leave a message at this number? ❑Yes ❑No

Email Address _____

Father/Husband _____ Marital Status _____ SS # _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____

Employer _____ Address _____

City _____ Zip _____

Mother/Wife _____ Marital Status _____ SS # _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____

Employer _____ Address _____

Names/Ages of other children in family _____

Siblings/Friends treated here _____

Did either parent have orthodontic treatment? Mom When? _____ Where? _____

Dad When? _____ Where? _____

Referred By _____

Please bring in any insurance cards or information you may have to your next appointment. We will bill your insurance company for services rendered. Thank you.

Orthodontics for Adults and Children
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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 ❑ Stuffiness ❑ 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,	No ❑ Yes ❑	Aching Shoulders ❑ Stiffness ❑ Lack of Mobility ❑ Upper ❑ Lower ❑ Back Pain ❑ Numbness in Arms ❑	_____ _____
Extremity Problems	No ❑ Yes ❑	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	No ❑ Yes ❑	Ulcers ❑ Bleeding ❑ Abdominal Pain ❑ Heartburn ❑	_____
& Intestine Problems	No ❑ Yes ❑	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, Hemophylia, other) ❑ _____

Chronic Disease No ❑ Yes ❑ Diabetes ❑ Cancer ❑ Hepatitis A ❑ B ❑ Kidney ❑ _____
Swelling ❑ Tonsilitis ❑ 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 No ❑ Yes ❑ (ADULTS) _____ _____
_____ _____

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 ❑ _____ _____

How many cans of soda pop do you drink a day _____ / week _____ ?

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

Tooth Injury No ❑ Yes ❑ Chipped ❑ Broken ❑ Lost ❑ _____ *EXPLAIN IF YES*

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 Responsibile Party Date

_____ _____
Signature of Doctor Date

_____
Signature of Treatment Coordinator

_____
Date