

Health History Questionnaire

Patient Name: _____ Sex: M/F Age: _____ B Day: _____

Responsible Party (Child only) Mom: _____ Dad: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Cell: Mom: _____ Cell: Dad: _____

Email: _____

Do you have insurance for orthodontics? YES NO

Name of Dentist: _____ Name of referral: _____

Name of other health care providers: (MD, any specialists): _____

What is your (or your dentist's) primary orthodontic concern? _____

What is the patient's ethnic origin? Mom's: _____ Dad's: _____

MEDICAL HISTORY- Please circle Y or N for the following questions:

Is patient in good general health: Y/N Is Patient currently under the care of a physician: Y/N

Has patient reached puberty? Y/N

Any prolonged bleeding Y/N Nervous disorders Y/N Diabetes Y/N Allergies Y/N Bone Disorders Y/N HIV Y/N TB Y/N Fainting/Dizziness Y/N Gland problems Y/N Blood problems Y/N Epilepsy Y/N Infections Y/N Hepatitis Y/N Aids Y/N Immunity problem Y/N Pneumonia Y/N Anemia Y/N Heart trouble Y/N Kidney problem Y/N

Arthritis Y/N Auto accident Y/N Rheumatic fever Y/N Liver problem Y/N

Major trauma Y/N Asthma Y/N Syndrome Y/N Autism Y/N ADD/ADHD Y/N

Use the space below for information regarding any syndromes, disabilities or conditions:

DENTAL HISTORY- Please circle Y or N for the following questions:

Has the patient ever had any type of orthodontic treatment, including removable appliances? Y/N

Any other family members had orthodontic treatment? Y/N List: _____

Do you know if the patient has any missing adult teeth? Y/N or any extra teeth? Y/N

Any previous or ongoing thumb, finger habit? Y/N If yes, how long? _____

Any previous injury to face, chin, mouth, neck or teeth? Y/N: _____

Any speech problems? Y/N - which sounds?: _____

Has patient ever had speech therapy? Y/N

Is patient a mouth breather? Night Y/N Day Y/N Tonsils removed? Y/N Adenoids removed? Y/N

Does the patient (if child) have siblings? Y/N Please list names/ages: _____

Any difficulty or pain when opening or closing, chewing, yawning? Y/N _____

Is patient being treated for jaw joint disorders? Y/N

Frequent headaches? Y/N

Patient or responsible party Signature: _____

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care
COMMITMENT