Health History Questionnaire

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

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

Address: _____ City: _____ Postal Code: _____

Phone: _____ Mom Cell: _____ Dad Cell: _____

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 check Y or N for the following questions:

Is patient in good general health? Y ☐ N ☐ Is patient currently under care of a physician? Y ☐ N ☐

Has patient reached puberty? YES ☐ NO ☐

Any prolonged bleeding?	YES ☐	NO ☐		Nervous disorders?	YES ☐	NO ☐	
Diabetes?	YES ☐	NO ☐		Allergies?	YES ☐	NO ☐	
Bone disorders?	YES ☐	NO ☐		HIV?	YES ☐	NO ☐	
TB?	YES ☐	NO ☐		Fainting/Dizziness?	YES ☐	NO ☐	
Gland problems?	YES ☐	NO ☐		Blood problems?	YES ☐	NO ☐	
Epilepsy?	YES ☐	NO ☐		Infections?	YES ☐	NO ☐	
Hepatitis?	YES ☐	NO ☐		AIDS?	YES ☐	NO ☐	
Immunity problems?	YES ☐	NO ☐		Arthritis?	YES ☐	NO ☐	
Auto accident?	YES ☐	NO ☐		Rheumatic fever?	YES ☐	NO ☐	
Liver problems?	YES ☐	NO ☐		Major trauma?	YES ☐	NO ☐	
Asthma?	YES ☐	NO ☐		Syndrome?	YES ☐	NO ☐	
Autism?	YES ☐	NO ☐		ADD/ADHD?	YES ☐	NO ☐	

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

DENTAL HISTORY- Please check **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: YES ☐ NO ☐ Day: YES ☐ NO ☐

Tonsils removed? YES ☐ NO ☐ Adenoids removed? YES ☐ NO ☐

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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