Health History Questionnaire

Patient Name:_____Sex:M/F Age:_____B Day:_____
ResponsibleParty(Childonly)Mom:_____Dad:_____
Address:_____City:_____PostalCode:_____
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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