Health History Questionnaire

We are pleased that you have chosen our office for your orthodontic treatment. At the initial appointment a thorough examination will be completed and a preliminary diagnosis will be made. If orthodontic treatment is needed, diagnostic records will be required. For your convenience, time will be allotted for diagnostic records to be collected if necessary. Please allow approximately one hour for this visit.

We have enclosed this Medical/Dental questionnaire in order to obtain an accurate history of this patient. We find that if our patients complete this questionnaire in the comfort of their home, the history is more accurate. Please complete this entire questionnaire and ***bring it with you to your appointment***. Thank you.

We are looking forward to seeing you on: Day ________________, Date ________________ at: Time ________________ AM PM

Please provide us with the following information about this patient:

Patient's Last Name: ____, 1st ____ MI ______ Sex: M☐ F☐

Home Phone: ____________________________ (including area code) Cell Phone: ____________________________ (including area code) OK to receive text messages? Yes ☐ No ☐

Patient's Address: ____________________ (Street) ____________________ (City) ____________ (Zip) Birth date: ______________

School / Employer (circle one): ___________________________________ Work Phone: ____________________________ (including area code) Grade/Dept.: ________

Father/Husband (circle one): ____ Home Phone: ____________________________ (including area code) Marital Status: _____

Address (if different than pt.): ____________________ (Street) ____________________ (City) ____________ (Zip)

Cell Phone: ____________________________ (including area code) OK to receive text messages? Yes ☐ No ☐

Employer: ____ Work Phone: ____________________________ (including area code) OK to contact at office? Yes ☐ No ☐

E-mail: ____ Dental Insurance: ____

Insured's Name: _______________________________________ Insured's Birth Date: ________________ Insured's SSN: ______________________

Mother/Wife (circle one): ____ Home Phone: ____________________________ (including area code) Marital Status: _____

Address (if different than pt.): ____________________ (Street) ____________________ (City) ____________ (Zip)

Cell Phone: ____________________________ (including area code) OK to receive text messages? Yes ☐ No ☐

Employer: ____ Work Phone: _________________________ (including area code) OK to contact at office? Yes ☐ No ☐

E-mail: ____ Dental Insurance: ____

Insured's Name: _______________________________________ Insured's Birth Date: ________________ Insured's SSN: ______________________

I understand that by providing my email address I am allowing protected health information to be sent which may not be encrypted: Yes ☐

In case we can't reach you, who can we contact?

Person's Name: ______________________________________ Relationship: _______________________ Phone: _______________________ (including area code)

Financially Responsible Person: (If the patient, skip down to ➔ and complete the rest of the data)

Last: ____, 1st ________________________________ MI __________

Address: ____________________ (Street) ____________________ (City) ____________ (Zip) Relation to Pt.: ___________________________

➔ Residence: Own☐ Rent☐ Board ☐ How long living in this residence? ______years If less than 3 years, give previous residence:

Address: ____________________ (Street) ____________________ (City) ____________ (Zip) How long at that address? __________years

Home phone: ____________________________ (including area code) Work phone: ____________________________ (including area code) Cell phone: ____________________________ (including area code)

If you understand that when appropriate, credit bureau reports may be obtained, please sign ___________________________________ Date: _________________

Medical History for: ____
Patient's name

What is the name of your family physician? ________________________ Date of last visit: __________

Are there any Medical Specialists you see regularly? ________________________ Specialty: ______________

When was the last time you had a complete physical exam? Date ________ Examining Doctor's Name: ________________

What is your approximate height? _____ feet _____ inches Approximate weight? _____ pounds Body frame size: Sm ☐ Med ☐ Lg ☐

Mother's height __________ Father's height _________ Height of patient's oldest sibling _________ Oldest sibling's gender: M or F (circle one)

History of:		Specifics of Problems if YES:	Please explain. Indicate any Medication & dosage
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 ☐ Snoring ☐ Sleep Apnea ☐ Mouth Breathing ☐	____
Back, Shoulders, Extremity Problems?	No ☐ Yes ☐	Aching Shoulders ☐ Stiffness ☐ Lack of Mobility ☐ Back Pain ☐ Numbness in Arms ☐ Cramps in Legs: When Walking ☐ At Night ☐ Arm/ Leg Weakness ☐ Leg/Ankle Swelling ☐ Gout ☐	____
Bone Problems?	No ☐ Yes ☐	Break Easily ☐ Pain ☐ Arthritis ☐ Joint Pain ☐ Joint Swelling ☐	____
Breast Problems?	No ☐ Yes ☐	Pain ☐ Lumps ☐ Disease ☐	____
Heart Problems?	No ☐ Yes ☐	Coronary Heart Disease ☐ Heart Valve Disease ☐ High Blood Pressure ☐ Chest Pain ☐ Angina ☐ Heart Murmur ☐ Irregular Heartbeat ☐ Palpitations ☐ Rheumatic Heart Disease ☐ Congenital Heart Disease ☐ Mitral Valve Prolapse ☐	____
Urinary System Problems?	No ☐ Yes ☐	Urgency ☐ Painful Urination ☐ Frequent Urination ☐ Nighttime Urination ☐ Release when Sneeze/Cough ☐ Blood in Urine ☐ Kidney Infection ☐	____
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 ☐	____	____

DR __________ TC __________

History of:			Specifics of Problems if YES:	Please explain. Indicate any Medication & dosage
Kidney Problems?	No ☐	Yes ☐	____________	____________
Blood Problems?	No ☐	Yes ☐	Hemophilia ☐ Anemia ☐ Bruise Easily ☐ Bleed Easily ☐ Blood Clots ☐ Had Stroke ☐	____________
Chronic Disease Problems?	No ☐	Yes ☐	Diabetes ☐ Cancer ☐ Hepatitis A ☐ Hepatitis B ☐ HIV+ ☐ Tuberculosis ☐ Infectious Diseases ☐ AIDS ☐ Swelling ☐ Tonsillitis ☐ Excessive Colds ☐	____________
Skin Problems?	No ☐	Yes ☐	Eczema ☐ Dry ☐ Oily ☐ Itchy ☐	____________
One Time Problems?	No ☐	Yes ☐	Mumps (@ age ____) Rheumatic Fever (@ age ____) Measles (@ age ____) Chicken Pox (@ age ____)	____________
Heart Surgery?	No ☐	Yes ☐	Heart Valve (date _______) Pacemaker (date _______) Bypass (date ________) ____________ (date ________) other	____________
Other Surgery?	No ☐	Yes ☐	Tonsils (date _________) Adenoids (date _________)	____________
Serious Injury?	No ☐	Yes ☐	Broken Bones (date _________) __________	____________
Occupational Injury?	No ☐ (Adults)	Yes ☐	____________	____________
Habit Excesses?	No ☐	Yes ☐	Smoking (____ packs/day) for ____ years Caffeine ☐ Alcohol ☐ Over Eating ☐	____________
Exercise Regularly?	No ☐	Yes ☐	______ Hours Day ☐ Week ☐ Month ☐	____________
Psychological Problems?	No ☐	Yes ☐	Anxiety ☐ Depression ☐ Psychiatric Disorder ☐ Insomnia ☐ ____________ ☐ other	____________
Presently Taking Medications?	No ☐	Yes ☐	Birth Control ☐ Diuretics ☐ Blood Pressure ☐ Blood Thinners ☐ Heart ☐ Tranquilizers ☐ Anticonvulsant ☐ Insulin or similar drug ☐	____________
Allergies?	No ☐	Yes ☐	Hay Fever ☐ To Foods ☐ To Metals/Plastics ☐	____________
Drug Reactions?	No ☐	Yes ☐	Anti-Bacterial Drugs ☐ ____________	____________
Anesthetic Reaction?	No ☐	Yes ☐	Local Anesthetic ☐ General Anesthetic ☐	____________

Family History of:			If Yes, Which Family Members:	Comments on Family History of Diseases:
Diabetes?	No ☐	Yes ☐	____________	____________
Cancer or Skin Cancer?	No ☐	Yes ☐	____________	____________
Infectious Disease?	No ☐	Yes ☐	Tuberculosis ☐ Hepatitis ☐ HIV+ ☐ AIDS ☐	____________
Heart Disease?	No ☐	Yes ☐	____________	____________
High Blood Pressure?	No ☐	Yes ☐	____________	____________
Organ Disease?	No ☐	Yes ☐	Liver ☐ Kidney ☐ Lung ☐	____________
Kidney Disease?	No ☐	Yes ☐	____________	____________
Lung Disease?	No ☐	Yes ☐	____________	____________
Emotional Problems?	No ☐	Yes ☐	____________	____________
Stroke?	No ☐	Yes ☐	____________	____________
Arthritis?	No ☐	Yes ☐	____________	____________

Children: *Has the Patient Reached Puberty?*
Female started menstruation? No ☐ Yes ☐ (@ age ____) Males had voice change? No ☐ Yes ☐ (@ age ____)
Has a physician indicated that the patient is MATURING ☐ Earlier than normal ☐ Normally ☐ Later than normal

Women: *Are you pregnant now or do you think you may be?* No ☐ Yes ☐
Do you anticipate becoming pregnant? No ☐ Yes ☐

DR ___________ TC _________

Dental History:

Name of your family dentist: ______________________ Date of last visit: ____________

Dental Specialist(s) who has treated you (Name, Treatment, Date): ______________________

____

How many times per day do you *BRUSH* your teeth? 0 ☐ 1 ☐ 2 ☐ 3+ ☐

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

History of:		**Specifics of Problems if YES:**	**Please explain any YES answers**
Tooth Injury?	No ☐ Yes ☐	Chipped ☐ Broken ☐ Early loss ☐	______________
Jaw Injury?	No ☐ Yes ☐	At Age ______	______________
Oral Disease?	No ☐ Yes ☐	Ulcers ☐ Sores ☐	______________
Jaw Joint Pain?	No ☐ Yes ☐ No ☐ Yes ☐ Comments:	Right TMJ: Constant ☐ Periodic ☐ When you: Chew ☐ Yawn ☐ Talk ☐ Open Wide ☐ Left TMJ: Constant ☐ Periodic ☐ When you: Chew ☐ Yawn ☐ Talk ☐ Open Wide ☐ ______________	
Jaw Joint Noises?	No ☐ Yes ☐ No ☐ Yes ☐	Right TMJ: Click ☐ Pop ☐ Grating ☐ At Age: ______________ Left TMJ: Click ☐ Pop ☐ Grating ☐ ______________	
Jaw Joint Locking?	No ☐ Yes ☐ No ☐ Yes ☐	Right TMJ: When open ☐ When closed ☐ Dates of locking: ______________ Left TMJ: When open ☐ When closed ☐ ______________	
Grinding Teeth?	No ☐ Yes ☐	During the Day ☐ ______________ While Sleeping ☐ ______________	
Clenching Teeth?	No ☐ Yes ☐	During the Day ☐ ______________ While Sleeping ☐ ______________	
Bleeding Gums?	No ☐ Yes ☐	Usually ☐ Sometimes ☐ Rarely ☐ Presently under a dentist's care for it? Yes ☐ No ☐ 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 ______________	

Have you ever had:				**Doctor:**
Periodontal (gums) Treatment?	No ☐ Yes ☐	Type of Treatment?	______________	__________
Orthodontic (braces) Treatment?	No ☐ Yes ☐	Type of Treatment?	______________	__________
Endodontic (root canal) Treatment?	No ☐ Yes ☐	Type of Treatment?	______________	__________
Oral Surgery (jaw) Treatment?	No ☐ Yes ☐	Type of Treatment?	______________	__________
Prosthodontic (crown & bridge) Treatment?	No ☐ Yes ☐	Type of Treatment?	______________	__________

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 this practice of those changes.

______________________________ ____________

Signature of person completing this history Date completed

____

Signature of the TC who reviewed this HHQ

______________________________ ____________

Signature that the examining DOCTOR reviewed this history Date of exam/review of HHQ

____

Date the above TC reviewed the HHQ