

MEDICAL HISTORY

PT #: _____ office use only

We have enclosed this medical /dental history questionnaire because it is important that we obtain an accurate history. We find that when our patients complete this questionnaire in the comfort of their own home they are more accurate. Please complete this entire questionnaire and bring it with you to your appointment. Thank you and we look forward to seeing you.

Date _____

PATIENT'S NAME _____ Sex: M F Birthdate _____
Address _____ City _____ State _____ Zip _____
Email _____ Phone _____
Responsible Party: _____ Relation to Patient: _____
Date of last physical exam _____ Examining Doctors name _____
What is the name of your physician? _____ Date of last visit to your physician _____

For the following questions circle Yes or NO, whichever applies. (Your answers are for our records only and are confidential.)

- YES NO 1. Are you in good health?
YES NO 2. Has there been any change in your general health within the past year?
YES NO 3. Any medical specialist seen regularly? Specialty _____
YES NO 4. Have you had any serious illness, operation, or hospitalization?
If so, explain: _____
YES NO 5. Have your tonsils and /or adenoids been removed? When? _____
YES NO 6. Are you allergic to any drugs or medication? What? _____
YES NO 7. Do you have allergies to any other substances (i.e. pollen, pets, Latex, etc.)? _____
8. List any drugs or medicines you are taking. (even aspirin, vitamins, hormones, or antacids) _____
YES NO 9. Have you ever had any of the following childhood diseases? measles , chicken pox , mumps , scarlet fever , whooping cough
10. CHECK ANY OF THE FOLLOWING FOR WHICH YOU ARE/OR HAVE BEEN TREATED

- Heart Trouble Diabetes Arthritis Epilepsy Liver Involvement
 Anemia Pneumonia Thyroid Disorder Prolonged Bleeding Kidney Involvement
 High Blood Pressure Asthma Rheumatic Fever Malignancies Endocrine Problems
 Low Blood Pressure Tuberculosis Fainting or Dizziness Radiation Treatment Hepatitis
 Circulatory Problems Glaucoma Nervous Disorders Bone Disorder HIV/ Aids

- If checked, Explain and/or Other Conditions? _____
YES NO 11. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
YES NO a. Do you bruise easily?
YES NO b. Have you ever required blood transfusion? If so, explain the circumstances _____
YES NO 12. Do you have tendency to: Colds Sore Throats Ear Infections
YES NO 13. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck?
YES NO 14. Have you or any member of your family been exposed to hepatitis, tuberculosis, or AIDS?
If so, explain _____
YES NO 15. Do you have any Psychological Problems? Anxiety , Depression , Psychiatric Disorder , Insomnia _____
YES NO 16. Do you have any disease, condition, or problem not listed above that you think the doctor should know?
If so, explain _____

FEMALES

- 17. What age did menstruation begin? _____
YES NO 18. Do you have any problems associated with your menstrual period? _____
YES NO 19. Are you pregnant?
YES NO 20. Are you on birth control pills?
YES NO 21. Are you in or post menopause?

DENTAL HISTORY

- YES NO 22. Have there ever been any injuries to the face, mouth, or teeth? Explain _____
YES NO 23. Have you ever sucked your fingers or thumb? Until what age? _____
YES NO 24. Do you have any speech problems? Explain _____
YES NO 25. Are you a mouth breather? and /or do you snore? While awake? While asleep?
YES NO 26. Have you ever been informed of any missing or extra teeth? Explain _____
YES NO 27. Have you ever consulted or been treated by an orthodontist previously?
YES NO 28. Have either parent had orthodontic treatment? Mother Father
YES NO 29. Do you have pain in the jaw joints? Right Left When did it begin? _____
YES NO 30. Do you have popping or cracking jaw joints? Right Left When did it begin? _____

For your convenience, we are pleased to offer to those patients receiving treatment a monthly payment plan. We simply need to confirm your good credit record and our staff will gladly work with you on an acceptable payment schedule. _____ (Initial)

SIGN: _____ (Patient)
Social Security # _____

SIGN: _____ (Parent or Guardian)
Social Security # _____