

Getting To Know You

A Dento-Medical History Questionnaire

A B C

ADULT

DATE _____

NAME OF PATIENT _____ SOC. SEC. # _____

FIRST MIDDLE LAST

MALE _____ FEMALE _____ SINGLE _____ MARRIED _____ CHILDREN _____

AGE _____ BIRTHDATE _____ HOME TELEPHONE _____

MONTH DAY YEAR

HOME ADDRESS _____

NUMBER & STREET

CITY

ZIP

PATIENT EMPLOYED BY _____ BUSINESS PHONE _____ NO. OF YEARS _____

BUSINESS ADDRESS _____ CELL PHONE _____

SPOUSE'S FIRST NAME _____ EMPLOYED BY _____ NO. OF YEARS _____

SPOUSE'S BUS. ADDRESS _____ BUSINESS PHONE _____ CELL PHONE _____

PATIENT'S DENTIST _____ CITY _____

PATIENT'S PHYSICIAN _____ CITY _____

WHAT IS YOUR PRIMARY ORTHODONTIC CONCERN? _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Successful treatment depends greatly upon the Patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene. Are there any restrictions, handicaps or problems we might encounter? _____

NOW COMPLETE B through C.

MEDICAL HISTORY

DOES THE PATIENT **FREQUENTLY** HAVE ANY OF THE FOLLOWING CONDITIONS?

	YES	NO		YES	NO
Indigestion, nausea, vomiting, jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools or in Urine, Kidney or Bladder Condition	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea, constipation, abdominal cramps	<input type="checkbox"/>	<input type="checkbox"/>	Headaches, colds, or sore throats each year	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever, Asthma, Eczema, Hives	<input type="checkbox"/>	<input type="checkbox"/>	Allergies, Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>

HAS THE PATIENT **EVER** HAD ANY OF THE FOLLOWING CONDITIONS?

	YES	NO		YES	NO
Unhealthy infancy, breast- or formula-feeding difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Polio, Mono, Tuberculosis, Pneumonia, Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Bone fractures - any major accidents	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever, Heart Condition, Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Change in weight recently - poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	High or Low Blood Pressure - Tires easily?	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding - black and blue tendency	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia or "Hyperactive" condition, Muscle or Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Growths, tumors, unusual swellings	<input type="checkbox"/>	<input type="checkbox"/>	A nervous breakdown - Psychological, Emotional Condition	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes - Bowel or Urinary Condition	<input type="checkbox"/>	<input type="checkbox"/>	A tendency to cry or get upset easily - Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

Is Patient under a physician's care? _____ Why? _____

HIV Status: unknown positive negative

Please list any serious or recurrent illness (physical or mental) _____

Other physical problems or symptoms _____

Operated on for _____

Been hospitalized for _____

Allergies or Drug Reaction to _____

Is patient on medication? _____ Please name it _____

DENTAL HISTORY

	YES	NO		YES	NO
Start teething very early or late	<input type="checkbox"/>	<input type="checkbox"/>	Nail-biting habit to age _____	<input type="checkbox"/>	<input type="checkbox"/>
Baby teeth removed that were not loose	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing habit	<input type="checkbox"/>	<input type="checkbox"/>
Chipped or otherwise injured baby or permanent teeth	<input type="checkbox"/>	<input type="checkbox"/>	Tooth-grinding, jaw-clenching, clicking, locking, pain	<input type="checkbox"/>	<input type="checkbox"/>
Teeth sensitive to hot or cold. Teeth throb or ache	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty encountered in breathing, chewing	<input type="checkbox"/>	<input type="checkbox"/>
Jaw fractures, cysts, abscess, other infections	<input type="checkbox"/>	<input type="checkbox"/>	Presently have extra or congenitally missing teeth	<input type="checkbox"/>	<input type="checkbox"/>
"Dead teeth" - root canals treated	<input type="checkbox"/>	<input type="checkbox"/>	Permanent or "Extra" (super-numerary) teeth removed	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums, bad taste, mouth odor	<input type="checkbox"/>	<input type="checkbox"/>	Aware of loose, broken, or missing restorations (fillings)	<input type="checkbox"/>	<input type="checkbox"/>
Gingivitis, "Vincents" infection, "Pockets"	<input type="checkbox"/>	<input type="checkbox"/>	Any teeth irritating cheek, lip, tongue, palate	<input type="checkbox"/>	<input type="checkbox"/>
Food impaction between teeth, Periodontal Problem	<input type="checkbox"/>	<input type="checkbox"/>	Concerned about spaced, crooked or protruding teeth	<input type="checkbox"/>	<input type="checkbox"/>
"Gum Boils" - frequent canker sores, "cold sores"	<input type="checkbox"/>	<input type="checkbox"/>	Aware of or concerned about under- or over-developed jaw	<input type="checkbox"/>	<input type="checkbox"/>
Lip-, Cheek-, Tongue-biting, soreness, or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Any relative with similar tooth or jaw relationship	<input type="checkbox"/>	<input type="checkbox"/>
Thumb-, Finger-, Tongue-sucking habit until age _____	<input type="checkbox"/>	<input type="checkbox"/>	Any wisdom tooth problem	<input type="checkbox"/>	<input type="checkbox"/>
			Abnormal Swallowing Habit (Tongue Thrust) to age _____	<input type="checkbox"/>	<input type="checkbox"/>

Has Patient had any other dental condition or symptom (Explain) _____

Has Patient recently been under another dentist's care (specialist - other?) _____

Would Patient object to wearing orthodontic appliances (braces) should they be indicated? _____

I understand, that where appropriate, credit bureau reports may be obtained.

Does he/she follow instructions readily? _____

Has Patient ever had Orthodontic Treatment or worn a "retainer" or bite plate? _____

Has Patient ever had Periodontal Treatment or "Gingivectomy"? _____

SIGNED _____