

Orthodontic Medical Questioner

Patient Name _____ Date _____ Chart# _____

Are you in poor health? YES NO
 Are you under the care of a physician? YES NO
 If yes, why? _____
 Have you had any serious illness or operation? YES NO
 If yes, why? _____
Do you have or have had any of the following diseases or problems:
 Damaged or artificial heart valves YES NO
 Congenital heart lesions or murmurs YES NO
 Cardiovascular disease (heart trouble) YES NO
 Are you short of breath after mild exercise? YES NO
 Do you have a cardiac pacemaker? YES NO
 Have you ever had rheumatic fever? YES NO
 Sinus trouble YES NO
 Asthma YES NO
 Hives or skin rash YES NO
 Fainting spells or seizures YES NO
 Diabetes YES NO
 Hepatitis, jaundice or liver disease YES NO
 HIV/AIDS YES NO
 Arthritis/rheumatism/painful joints YES NO
 Stomach ulcers YES NO
 Kidney trouble YES NO
 Tuberculosis YES NO
 Persistent cough, or cough up blood YES NO
 Low blood pressure YES NO
 Venereal disease YES NO
 Have you had abnormal bleeding associated with previous extraction, surgery or trauma? YES NO
 Do you bruise easily? YES NO
 Have you had a blood transfusion? YES NO
 If yes, why? _____
 Have you ever taken Redux or Fen-Phen? YES NO
 Are you pregnant? YES NO
 Do you have anemia or other blood disorder? YES NO

Are you taking any of the following medicines:
 Antibiotics/sulfa YES NO Blood pressure YES NO
 Cortizone/Steroids YES NO Insulin/diabetes YES NO
 Digitalis/heart YES NO Blood thinners YES NO
 Thyroid YES NO Antihistamine/Allergy YES NO
 Tranquilizers YES NO Aspirin/Pain YES NO
 Nitroglycerin YES NO Cold/Flu YES NO
 If yes to any of the above, please list name and dosage:

Are you allergic or have you had a reaction to:
 Local anesthetics YES NO
 Barbiturates/Sedatives/Sleeping pills YES NO
 Antibiotics/Penicillin/Sulfa YES NO
 Aspirin/Codeine YES NO
 Latex or rubber products YES NO
 Nickel or other metals YES NO

Other allergies _____
 Do you have any other disease, condition or problem that you think I should know about? YES NO
 If yes, what? _____

Do you have a
 -prosthetic hip _____ - joint prosthesis _____
 - implant _____ - bone plates _____
 - bone screws _____ - other _____

Do you have any of the following:
 Bleeding/sore gums YES NO Blister/sores YES NO
 Popping/pain in jaw YES NO Change in bite YES NO
 Loose/sensitive teeth YES NO Shifting of teeth YES NO
 Biting cheeks YES NO Jaw locks open YES NO

Your medical doctor is:
 Name _____
 Address _____
 Phone _____

By signing I certify that I have read and filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further consent to necessary x-rays and orthodontic exam for myself or the above named minor, of whom I am parent or legal guardian.

Patient/parent/guardian _____ Date _____

Dentist _____ Date _____

UPDATE/CHANGES

Patient/parent/guardian _____
 Dentist _____
 Date _____

Patient/parent/guardian _____
 Dentist _____
 Date _____