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 _____

PATIENT NAME_____ CHART NUMBER_____ OFFICE_____

CHIEF COMPLAINT_____

LAST DENTAL VISIT_____

DENTITION PRESENT

E D C B A	A B C D E
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
E D C B A	A B C D E

CLASS	R MOLAR	R CUSPID	L MOLAR	L CUSPID
I				
II DIV 1				
II DIV 2				
III				

_____NONE MX ALD _____MM ANT _____MM

_____NONE MD ALD _____MM ANT _____MM

_____NONE CROSSBITE

_____NORM OB CLOSED_____% OPEN_____MM

_____NORM OJ +_____MM -_____MM E/E_____

_____NORM SPEE DEEP_____FLAT_____REVERSE_____

_____NORM ML REST CO

_____NORM CLOSE ____MM M____D____PS CL III____

_____NORM LIPS STRAINED_____ APART_____

_____NORM TONE HYPO_____ HYPER_____

_____NORM FRENUM MX_____ MD_____ SURG_____

_____NORM T&A NONE_____ LARGE_____ REF_____

_____NORM ERUPTION EARLY_____ LATE_____

_____NORM PROFILE MX PR__RT__ MD PR__RT__

_____NORM OH GP_____ PERIODONTIST_____

_____NORM SOFT TISSUE/CANCER _____

_____NORM TMJ CLICKS LEFT_____ RIGHT_____
PAIN LEFT_____ RIGHT_____
LOCKS LEFT_____ RIGHT_____

_____NONE HABITS TT FR_____LAT_____REF_____
LIP_____ THUMB_____MBR_____
OTHER_____

HEALTH HX REVIEWED _____DATE_____

TX: FULL PHI PHII PART NO TX RECALL_____MO

CEPHALOMETRIC OB_____ OJ_____ E_____
SKELETAL_____
DENTAL _____

	PLAQUE				POCKET DEPTH						BLEEDING			
	DB	B	MB	L	DB	B	MB	ML	L	DL	DB	B	MB	L
3														
8														
13														
19														
24														
28														

PERIO TYPE: O I II III IV

PRELIMINARY TREATMENT PLAN

FINAL TREATMENT PLAN

ESTIMATED TREATMENT LENGTH_____MONTHS

DR_____PT/PARENT_____DATE_____

ALT/REVISED TX PLAN

DR_____PT/PARENT_____DATE_____

ALT/REVISED TX PLAN

DR_____PT/PARENT_____DATE_____

ALT/REVISED TX PLAN

DR_____PT/PARENT_____DATE_____