

HEALTH QUESTIONNAIRE

Patient's Physician:

Physician's Phone Number:

As far as you know, are you in good health?

YES NO

Do you have or have you ever had any of the following:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Congenial Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Stomach Disease |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> None of the Above |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other_____ |

Following injury, do you bleed excessively?

YES NO

Have you ever been hospitalized for something serious?

YES NO

If yes, for what?

Are you under the care of a physician?

YES NO

If yes, for what?

Are you taking any of the following:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Nitroglycerin | <input type="checkbox"/> Anticoagulants (blood thinners) |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Analgesics (pain killers, aspirin codeine) |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> Steroids (cortisone) | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Medicine for High Blood Pressure |
| <input type="checkbox"/> Digital or Heart Trouble Drugs | <input type="checkbox"/> None | | |

Are you allergic or have you reacted badly to the following:

- Local Anesthetics Penicillin Antibiotics Aspirin Ibuprofen Tylenol None

Are you allergic or have you reacted badly to the following:

- Metals Plastics Latex Dentists Other known allergies:

Are you taking any medication that gives you dry mouth such as acne medication?
(Such medicine leads to staining and decay)

YES NO

If you are a female, are you pregnant or trying to get pregnant?

YES NO

Do you require medication before dental treatment?

YES NO

Miscellaneous

- ❖ Brushing daily around the brackets is an absolute must in order to prevent tooth staining, gum inflammation and tooth decay.
- ❖ Understand that the exact length of treatment is unknown and can continue beyond the expected time.
- ❖ Most common problems associated with braces are: irreversible staining, gum problems, uneven bite, short roots and tooth loss. Any other problems should be addressed with your regular dentist at your own expense.

PATIENT / PARENT SIGNATURE:

DATE: