

Health Questionnaire (Adults)

Family name _____

First name _____

Nickname or preferred name _____

Date of Birth (m/d/y) _____

Sex: Male Female

Age _____ Weight _____ Height _____

Marital Status _____

Residence:

Address
City
Postal code
Phone
E-mail
Cell

Business:

Company
Address
City
Postal Code
Phone
E-mail
Occupation

Who may we thank for referring you to Red Hill Orthodontics? _____

Your dentist's name _____

Date of your last dental check-up _____

Your physician's name _____

Dental Insurance Details: (if applicable)

Name of insurance company _____

Do you have orthodontic coverage: Yes No

Name of policy holder _____

Relationship to patient _____

Group number _____

Certificate number _____

Person responsible for account (if not yourself) _____

Medical and Dental Information

- | | Yes | No |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Under the care of a physician within the last 5 years? If yes, why? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. History of any serious illnesses? Please explain. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking or have you been given intravenous bisphosphonates (such as Zometa or Aredia) For bone cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking or have you been given oral or intravenous bisphosphonates (such as Fosamax, Actonel, Boniva, Reclast, Skelid, Didronel, or Bonefos) for osteoporosis, osteopenia, or other uses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you taking any medications (vitamins, medicines or drugs) at the present time? If yes, which ones? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had or been treated for (Please circle): | | |

- | | | | | | |
|-----------|-------------------|----------------|-------------------|-----------|---------------|
| Cancer | Rheumatic fever | Blood pressure | Thyroid disorders | Anemia | A.I.D.S. |
| Asthma | Stomach disorders | Heart trouble | Eye trouble | Epilepsy | Other S.T.D.s |
| Sinusitis | Liver disease | Joint problems | Kidney disease | Hay fever | |
| Diabetes | Blood disorders | Tuberculosis | Gall bladder | Hepatitis | |

- | | Yes | No |
|-----------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 7. Do you have any allergies? If yes, to what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had any adverse effects from any anesthetic, antibiotic or other medical drugs? If yes, which ones? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have shortness of breath or difficulty breathing through your nose or mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had any radiation or X-ray therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you get infections easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have a heart murmur or heart disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you get night sweats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you get frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has your jaw ever locked closed or open? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you grind or clench your teeth at night? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you or have you ever had a history of thumb or finger sucking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a clicking or popping noise in your ear? Please specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

For our female patients only:

- | | | |
|---------------------------------------------------------|--------------------------|--------------------------|
| 19. Do you take birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Are you or do you suspect being currently pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

Date: _____

Signature: _____