Mystic Valley Orthodontics, P.C.

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ADULT HEALTH QUESTIONNAIRE

Welcome to our orthodontic office! In order to provide you with the best possible care, please complete the following form before your next visit. If you have any questions, please feel free to write them down and the doctor will review them with you at your appointment. Your answers are for our records only and are considered confidential. Thank you. ***Please answer ALL questions***

1. Full Name:_____ Date:_____
2. Nickname:_____ Referred By:_____
3. Date of Birth:_____ Parents name, address & phone if responsible for billing:
4. Home address:_____ _____
   City, Zip Code: _____ _____
5. Home Phone:_____ Work Phone:_____
   Cell Phone: _____ E-mail:_____
6. Your occupation: _____ Business Phone: _____
7. Spouse's name:_____ Spouse's Occupation:_____
8. Emergency Contact Person: As Above Other: _____
9. Physician's Name:_____ Physician's Phone:_____
   Address: _____ _____
10. Family Dentist:_____ Other Dental Specialist:_____
11. Do you have insurance that covers Orthodontics? □ Yes □ No □ Not sure
    If yes, Subscriber Name & Subscriber#:_____
    Subscriber's Employer: _____Group #:_____
    Please bring two completed insurance forms at your first visit. Thank you.
12. What do you think is your chief orthodontic problem? _____
    _____
13. What did your dentist tell you may possibly be done to correct the problem? _____
    _____

*We confirm all of our appointments by email. Please provide us with the best email to contact you:

E-mail Address: _____

*****Please check the ***Best*** telephone # to reach you during the day:

Home □ _____
Work □ _____
Cell □ _____

MEDICAL HISTORY

1. Other than the usual childhood diseases (measles, chicken pox, etc.), have you ever had any other illnesses of any kind? Yes ___ No ___
   If yes, please give name of illness/es: _____
   _____

2. Have you ever been hospitalized for any reason? Yes ___ No ___
   If yes, please give reason, age and extent of hospitalization: _____
   _____

3. Do you take pills or medication now for any reason? Yes ___ No ___
   If yes, please list below:

   Name of medication/s: Reason for taking medication/s: Medication dosage and frequency:

   a. _____ _____ _____

   b. _____ _____ _____

   c. _____ _____ _____

   d. _____ _____ _____

4. Do you have any allergies? If so, please specify _____

5. Have you ever taken fluoride tablets? If so, when and for how long? _____

6. Are there any problems with speech? If so, please specify_____
   _____

7. *Women:* Are you pregnant or nursing? Yes ___ No ___

   Do you take oral contraceptives? Yes ___ No___

8. Do you take Fosamax or any other bisphosphonate therapy for bone density? If so, which one and what is the dosage? Yes ___ No___ _____

REVIEW OF SYSTEMS

Have you ever had, or now have any of the following?

Skin

Itching	__ Yes __ No
Rash	__ Yes __ No
Ulcers	__ Yes __ No
Pigmentations	__ Yes __ No
Lack/loss of body hair	__ Yes __ No
Extremities	__ Yes __ No

Extremities

Varicose veins	__ Yes __ No
Swollen, painful joints	__ Yes __ No
Muscle weakness, pain	__ Yes __ No
Bone deformity, fracture	__ Yes __ No
Prosthetic joints	__Yes __No
Osteopoenia	__Yes __No
Osteoporisis	__Yes __No

Eyes

Blurring of vision	__ Yes __ No
Double vision	__ Yes __ No
Drooping of eyelid	__ Yes __ No
Glaucoma	__ Yes __ No

Ear, Nose, Throat

Earache	__ Yes __ No
Hearing loss	__ Yes __ No
Frequent nosebleeds	__ Yes __ No
Sinusitis	__ Yes __ No
Frequent sore throat	__ Yes __ No
Hoarseness	__ Yes __ No

Respiratory

Cough, blood in sputum	__ Yes __ No
Bronchitis, emphysema	__ Yes __ No
Wheezing, asthma	__ Yes __ No
Tuberculosis, exposure to	__ Yes __ No

Cardiac

Shortness of breath	__ Yes __ No
Pain, pressure in chest	__ Yes __ No
Heart attack	__ Yes __ No
Swelling of ankles	__ Yes __ No
High/low blood pressure	__ Yes __ No
Rheumatic, scarlet fever	__ Yes __ No
Heart Murmur	__ Yes __ No
Prosthetic valves/pacemaker	__ Yes __ No
Mitral valve prolapse	__ Yes __No
Organ transplant	__ Yes __No

Gastrointestinal

Difficulty swallowing	__ Yes __ No
Abdominal pain, ulcers	__ Yes __ No
Jaundice, Hepatitis-A, B, C	__ Yes __ No
Liver disease	__ Yes __ No

(If so, any RX? & what was RX)

Genitourinary

Difficulty/pain on urination	__ Yes __ No
Blood in urine	__ Yes __ No
Excessive urination	__ Yes __ No
Kidney problems/transplant	__ Yes __ No
Sexually transmitted diseases	__ Yes __ No

Endocrine

Thyroid trouble	__Yes__No
Weight change	__Yes__No
Diabetes	__Yes__No
Excessive thirst	__Yes__No
Organ transplant	__Yes__ No

(If yes, which organ? _____)

Hematopoietic

Easy bruising, persistent bleeding __Yes __No

Persistent lymphadenopathy	__ Yes __ No
G6PD deficiency	__ Yes __ No
Anemia	__ Yes __ No
HIV infection, AIDS	__ Yes __ No
Leukemia, immune system prob.	__ Yes __ No
Spleen problems	__ Yes __ No

Neurologic

Frequent headaches	__ Yes __ No
Epilepsy, fits	__ Yes __ No
Neuritis, neuralgia	__ Yes __ No
Parasthesias, numbness	__ Yes __ No
Paralysis	__ Yes __ No
ADHD	__Yes __No

Autism Spectrum Disorder (ASD) __Yes__No

Psychiatric

Nervousness, irritability	__ Yes __ No
Anxiety	__ Yes __ No
Depression	__ Yes __ No
Nervous breakdown	__ Yes __ No

Growth or Tumor

Radiotherapy	__Yes__No
Chemotherapy	__ Yes __ No

***Do you have a medical condition that requires yourself to need <u>Antibiotic Prophylactic Premedication</u> such as amoxycillin, erythromycin, clindamycin, etc. prior to undergoing dental procedures?**

Yes _____ or No _____ If yes, please list:

Name of antibiotic: **Reason for taking antibiotic premedication:** **Dosage and frequency:**

_____ _____ _____

DENTAL HISTORY

1. When was the approximate date of the last dental visit? _____

2. What was done at that time? _____

3. Have any dental x-rays been taken within the last six months? Yes ___ No ___

4. Has your child had any extractions of baby or permanent teeth? Which ones and for what reason were they extracted? _____ Dates: _____

5. Have there been any injuries or blows to any of the teeth? Yes ___ No ___

6. Have you had any toothaches or complaints about sensitivity to hot, cold or sweets in any permanent teeth at any time? _____

7. Have you ever had or do you now have any habits such as thumb sucking, nail biting, tongue habits, or grinding the teeth? _____

8. Do you have any pain, cracking, popping or noise in the jaw joint near the ears? Any pain in the morning? Yes___ No ___ If so, how long has pain persisted? _____
_____

9. Do you have frequent canker or cold sores? Yes ___ No ___

10. Do you gag easily? Yes ___ No ___

11. Do you smoke? Yes ___ No ___

SOCIAL HISTORY

1. Family dental history: What type, if any, orthodontic problem do each of these relations have?

   Father: _____
   Mother: _____
   Siblings:_____
   Children: _____

2. Other interests? (sports, hobbies, musical instruments, etc.)

   _____
   _____
   _____

3. What is your present feeling about the possibility of having braces?

   _____
   _____
   _____

4. **Is there anything else in your medical, dental, social or emotional history that you feel the doctor should know that may impact our treatment results? Please fully explain:**

   _____
   _____
   _____

I certify that any and all questions I had about the inquires above have been answered to my satisfaction and I have answered these questions truthfully and completely. I will not hold my orthodontist, or any other member of his/her staff responsible for any errors or omissions that I may have made.

I addition, I understand that all treatments, x-rays, laboratory fees and examinations are to be paid for as they are received or definite financial arrangements are to be made in advance.

_____ _____
Patient's Signature Date

_____ _____
Dentist Signature Date