MEDICAL QUESTIONNAIRE

This questionnaire will be kept completely confidential. Certain medical conditions can have an influence on dental health. Dental treatment may affect medical conditions. Please answer all questions as fully as possible. If you are unsure of any matters please discuss these with your orthodontist.

Physician's Name: _____ Date of Last Check-up: _____

If this patient sees any medical specialists, please list them: _____

1. Is this patient being treated for any medical condition (within the last year): YES ❑ NO ❑

   If yes, describe: _____

2. Is this patient taking any medications or non-prescription drugs of any kind? YES ❑ NO ❑

   Medication _____ Strength _____ Frequency _____

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   Medication _____ Strength _____ Frequency _____

3. Does this patient take any bisphosphonate medication? YES ❑ NO ❑
4. Does this patient have any allergies? YES ❑ NO ❑

   If yes, list: 1. Drugs or medications: _____

   2. Latex _____ 3. Other _____

5. Does this patient have any heart problems? YES ❑ NO ❑
6. Does this patient have a heart murmur or mitral valve prolapse? YES ❑ NO ❑
7. Has this patient ever had rheumatic fever? YES ❑ NO ❑
8. Has this patient ever had jaundice, hepatitis, or liver disease? YES ❑ NO ❑
9. Has this patient ever been told he/she should not give blood? YES ❑ NO ❑
10. Does this patient have any condition that could affect the immune system (Leukemias, AIDS, HIV positive, etc.) YES ❑ NO ❑

    (please list) _____

11. Does this patient bruise or bleed easily or excessively? YES ❑ NO ❑
12. Has this patient ever been hospitalized for illness or surgery? YES ❑ NO ❑

    If yes, describe: _____

13. For women only, are you pregnant? YES ❑ NO ❑
14. Does this patient have or has he/she ever had any of the following?:

Anemia ( )	Diabetes ( )	High Blood Pressure ( )	Rheumatic fever ( )
Arthritis ( )	Epilepsy ( )	Low Blood Pressure ( )	Scarlet Fever ( )
Asthma ( )	Fainting spells ( )	Kidney Trouble ( )	Sexually Transmitted Disease ( )
Bleeding Disorder ( )	Glandular problems ( )	Liver Trouble ( )	Thyroid Problem ( )
Blood Disorders ( )	Hand/Neck Injury ( )	Artificial Joint ( )	Transplant/implant ( )
Cancer ( )	Heart Trouble ( )	Artificial Heart Valve ( )	Tuberculosis ( )
Chest Pain ( )	Hepatitis ( )	Radiation or X-ray therapy ( )	Ulcers ( )

If there are any conditions or diseases not listed above, that this patient currently has or has had in the past, please describe:

_____

DENTAL QUESTIONNAIRE

1. PERSONAL INFORMATION:

Patient's Name: _____ Date of Birth: _____ Age: _____

Responsible Party: _____ Address: _____

City: _____ Postal Code: _____ Home Telephone: _____

Business Telephone: _____ Email: _____

Alternate contact numbers we may use (eg. cell phone):_____

General Dentist: _____ Date of Last Check-up: _____

Who may we thank for referring you to our office? _____

(If you were not referred, how did you hear about this office?)_____

Do you have Dental Insurance which may cover orthodontic treatment? YES ❑ NO ❑

2. DENTAL HISTORY:

Do you/does this patient see a dentist regularly? YES ❑ NO ❑

Date of last dental visit? _____

Has this patient had any previous orthodontic treatment? YES ❑ NO ❑

If yes, please describe: _____

Has anyone else in the family had orthodontic treatment? _____

Please describe in your own words, any orthodontic problem you/your child may have:_____

_____

Please list any other concerns you may have regarding orthodontic treatment: _____

_____

Have you/has your child ever been advised to take antibiotics before dental appointments? YES ❑ NO ❑

Do you/does your child have any problems with the jaw joints (TMJ's)? YES ❑ NO ❑

Describe: _____

_____

Have you/has your child ever had any jaw joint implants or jaw surgery? YES ❑ NO ❑

Other dental treatments such as extractions, periodontal treatment, surgery? _____

3. CONSENT TO CONSULTATION AND TRANSFER OF RECORDS:

In the course of orthodontic treatment, it is often necessary to consult with the patient's general dentist, as well as other dental and medical specialists. This may include the transfer of dental/medical records from one practitioner to another. This is necessary so that dental and orthodontic care may be co-ordinated in an orderly manner. Do you consent to the consultation between your/your child's orthodontists and your/your child's other dental and health care practitioners, including the transfer of records between practitioners, from time to time, as required?

YES ❑ Signature: _____ Date:_____