Health Questionnaire

Today's Date ______________________

Patient Name ____ **DOB** ____/ ____/ __________

Does the patient have a history of the following medical conditions? Please circle YES or NO for each one.

AIDS/ HIV	YES / NO	Drug allergies	YES / NO	Painful chewing	YES / NO
Allergies	YES / NO	Emotional Disorders	YES / NO	Periodontal disease	YES / NO
Arthritis	YES / NO	Epilepsy	YES / NO	Prolonged bleeding	YES / NO
Aspirin regimen	YES / NO	Dizziness	YES / NO	Seizures	YES / NO
Asthma	YES / NO	Finger sucking	YES / NO	Sleep apnea	YES / NO
Bone disorders	YES / NO	Frequent headaches	YES / NO	Speech disorder	YES / NO
Bulimia/ Anorexia	YES / NO	Heart condition	YES / NO	Thumb sucking	YES / NO
Cancer	YES / NO	Hepatitis	YES / NO	When stopped?	
Cerebral Palsy	YES / NO	High blood pressure	YES / NO	______________________	
Chronic neck pain	YES / NO	Immune problems	YES / NO	TMJ pain	YES / NO
Clenching /Grinding teeth	YES / NO	Kidney problems	YES / NO	Tongue habit	YES / NO
Clicking of the jaw	YES / NO	Low blood pressure	YES / NO	Tuberculosis	YES / NO
Cold sore/Herpes	YES / NO	Muscular disorder	YES / NO		
Diabetes	YES / NO	Nervous disorder	YES / NO		
Down syndrome	YES / NO	Organ transplant	YES / NO		

Please explain any YES answers from above ____

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Do you have any allergies to latex,, metals, etc? YES / NO Please list ____________________________________

Girls: Have you begun menstrual periods? YES / NO

Have your tonsils and/or adenoids been removed? YES / NO When? ______________________________

Is there any part of your mouth that is sensitive to pressure or temperature? *Please explain* ______________________

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Do your gums bleed when you brush your teeth? YES / NO Are you using an electric toothbrush? YES / NO

Have you ever experienced any unusual reactions or allergies to any of the following drugs?

Penicillin	YES / NO	Tylenol	YES / NO
Antibiotics	YES / NO	Valium	YES / NO
Aspirin	YES / NO	Others	YES / NO

Please list all current medications and herbal supplements you are currently taking: ______________________________

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Signed consent

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.
I hereby authorize Egger Orthodontics to perform an orthodontic evaluation and consent to the taking of the necessary x-rays, photographs and other diagnostic records to determine appropriate orthodontic treatment on the above-named patient.

Patient Signature (Parent if a minor) ____ **Date** ____/ ____/ _________