Phelan ORTHODONTICS
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Date:

DENTAL & MEDICAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**	**AGE:**
Name patient prefers to be called:			
Primary Concern:	**Patient's Dentist:** *(and date last seen)*		

DENTAL HISTORY

Now or in the past has the patient had: (*explain any 'Yes' answers in the space below*)			
Started teething very early or late?	☐ Yes ☐ No	Any injuries/trauma to the face, mouth, or teeth? Chipped/fractured teeth? Fractured jaws?	☐ Yes ☐ No
Baby teeth removed by the dentist?	☐ Yes ☐ No	Clinch or grind teeth?	☐ Yes ☐ No
Permanent teeth removed by the dentist?	☐ Yes ☐ No	Speech problems?	☐ Yes ☐ No
Currently undergoing any dental treatment with the dentist?	☐ Yes ☐ No	Overactive gagging reflex?	☐ Yes ☐ No
Ever been informed of any missing or extra permanent teeth?	☐ Yes ☐ No	Any trouble or apprehension associated with any previous dental office visits or dental treatment?	☐ Yes ☐ No
Ever been treated by another dental specialist? (oral surgeon, endodontist, periodontist)	☐ Yes ☐ No	Would the patient object to wearing braces if needed?	☐ Yes ☐ No
Any previous orthodontic treatment or consultation?	☐ Yes ☐ No	Are there any self-esteem concerns for the patient with respect to how the teeth look?	☐ Yes ☐ No
Does patient generally have good oral hygiene?	☐ Yes ☐ No	Allergic to latex or any metals?	☐ Yes ☐ No
Any thumb, finger, or lip habits in the past, or present? If so, until what age?	☐ Yes ☐ No		

Explain any 'Yes' answers from above:

Please complete the backside.

MEDICAL HISTORY			
Patient's Physician:		**Date last seen:**	
Now or in the past has the patient had: (*explain any 'Yes' answers in the space below*)			
Overall, is the patient in good health?	☐ Yes ☐ No	Recent hospitalizations?	☐ Yes ☐ No
Birth defects or hereditary problems?	☐ Yes ☐ No	Eating disorder, anorexia, or bulimia?	☐ Yes ☐ No
Bone fractures or disorders? Any prosthetic/artificial joints?	☐ Yes ☐ No	Bleeding disorder, bruises easily, or anemia?	☐ Yes ☐ No
Arthritis?	☐ Yes ☐ No	High or low blood pressure?	☐ Yes ☐ No
Endocrine or thyroid problems?	☐ Yes ☐ No	Cardiovascular problems? (heart defects, heart murmur, valve problems/prolapse, congenital heart defects, stroke)	☐ Yes ☐ No
Kidney problems?	☐ Yes ☐ No	Chest pain, shortness of breath or swollen ankles?	☐ Yes ☐ No
Diabetes?	☐ Yes ☐ No	Tires or fatigues easily?	☐ Yes ☐ No
Cancer, tumors, radiation treatment, or chemotherapy?	☐ Yes ☐ No	Skin disorders?	☐ Yes ☐ No
Digestive or stomach problems?	☐ Yes ☐ No	Asthma, hayfever, or sinus trouble?	☐ Yes ☐ No
Polio, mononucleosis, tuberculosis, or pneumonia?	☐ Yes ☐ No	Eye, ear, nose, or throat conditions?	☐ Yes ☐ No
Immune system problems?	☐ Yes ☐ No	Tonsil or adenoid conditions or removal?	☐ Yes ☐ No
AIDS or HIV positive? *(Arkansas law requires that you inform health care provider)*	☐ Yes ☐ No	Allergic to any medications?	☐ Yes ☐ No
Liver problems, hepatitis, or jaundice?	☐ Yes ☐ No	Reached puberty yet?	☐ Yes ☐ No
Epilepsy, seizures, neurological problems, or fainting spells?	☐ Yes ☐ No	Girls—Is the patient pregnant or anticipating becoming pregnant? (need to know for x-ray purposes)	☐ Yes ☐ No
Nervous disorders, mental health, or behavioral problems?	☐ Yes ☐ No	Does the patient smoke or use smokeless tobacco?	☐ Yes ☐ No
Vision, hearing, tasting, or speech problems?	☐ Yes ☐ No	Taking any prescription medications? List below and give reasons.	☐ Yes ☐ No
Unexplained loss of weight recently?	☐ Yes ☐ No		
Explain any 'Yes' answers from above:			

Informed of HIPPA form online? ☐ Yes ☐ No

For self check-in, first and last name will be listed on an iPad at the front desk.

I have read understand the above questions. I will not hold my orthodontist or any member of the staff responsible for any errors or omissions that I have make in the completion of this form. If there are any changes later to the patient's health history or medical status, I will inform this practice.

Signed:_____ Date:_____
(Parent or Guardian)

Signed:_____ Date:_____
(Orthodontic Staff Member)