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 you prefer to be called:			
Primary Concern:	**Your Dentist:** *(and date last seen)*		

DENTAL HISTORY

Now or in the past have you: *(explain any 'Yes' answers in the space below)*

Any previous orthodontic treatment or consultation? If so by whom?	☐ Yes ☐ No	Periodontal or 'gum' problems? Periodontal treatment?	☐ Yes ☐ No
Concerned about spaced, crooked, or protruding teeth?	☐ Yes ☐ No	Pain or soreness in the muscles of the face, or around the ears? Clinch or grind teeth?	☐ Yes ☐ No
Concerned about under- or over-developed jaw?	☐ Yes ☐ No	Previous treatment for TMJ problems?	☐ Yes ☐ No
Any relatives with similar jaw relationship?	☐ Yes ☐ No	Difficulty in chewing or jaw opening?	☐ Yes ☐ No
Do you wear a retainer(s)?	☐ Yes ☐ No	Any current dental restorations planned by dentist?	☐ Yes ☐ No
Any missing or extra permanent teeth?	☐ Yes ☐ No	Any injuries/trauma to the face, mouth, or teeth? Chipped/fractured teeth? Fractured jaws?	☐ Yes ☐ No
Ever been treated by another dental specialist?	☐ Yes ☐ No	Any wisdom tooth problems?	☐ Yes ☐ No
Any permanent teeth removed by the dentist or oral surgeon?	☐ Yes ☐ No	Overactive gagging reflex?	☐ Yes ☐ No
Have interest in or need for dental implants?	☐ Yes ☐ No	Would you object to wearing braces if needed?	☐ Yes ☐ No
Abscesses, cysts or dental infections?	☐ Yes ☐ No	Interested in Invisalign?	☐ Yes ☐ No
Root canal treated teeth?	☐ Yes ☐ No	Allergic to latex or any metals?	☐ 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 have you had: (*explain any 'Yes' answers in the space below*)			
Overall, are you in good health?	☐ Yes ☐ No	Hospitalizations?	☐ Yes ☐ No
Birth defects or hereditary problems?	☐ Yes ☐ No	Eating disorder, anorexia, or bulimia?	☐ Yes ☐ No
Bone fractures or disorders, osteoporosis? 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 or urogenital problems?	☐ Yes ☐ No	Chest pain, shortness of breath or swollen ankles?	☐ Yes ☐ No
Diabetes?	☐ Yes ☐ No	Tire or fatigue 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	Females—Are you pregnant or anticipating becoming pregnant? (need to know for x-ray purposes)	☐ Yes ☐ No
Epilepsy, seizures, neurological problems, or fainting spells?	☐ Yes ☐ No	Drug or substance abuse problem?	☐ Yes ☐ No
Nervous disorders, mental health, or behavioral problems?	☐ Yes ☐ No	Do you 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 and 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 made in the completion of this form. If there are any changes later to my health history or medical status, I will inform this practice.

Signed:_____ Date:_____
(Patient)

Signed:_____ Date:_____
(Orthodontic Staff Member)