CDF FAMILY ORTHODONTICS
Let Your Smile Shine

HEALTH QUESTIONNAIRE

Please note that if the form is being completed by a parent or guardian, all questions below pertain to the patient, and not the parent or guardian.

Date: _____ Patient's Name :_____ Date of Birth: : _____
Patient's Marital Status: Single_____ Married_____ Divorced_____ Widowed_____
Patient's preferred gender: Male_____ Female_____ Other ____
School / Grade:_____
Occupation / Employer : _____
Parent or Guardian (If patient is a minor): _____
Address:_____ Zip:_____
Patient Home Phone:_____ Cell Phone:_____
(Parent / Adult Patient)
Work Phone:_____ Email Address:_____
(Parent / Adult Patient) (Parent / Adult Patient)

In your own words please describe the orthodontic problem as you see it :

_____

By whom were you directly referred?

_____

SECTION A- MEDICAL AND DENTAL INFORMATION

Medical Doctor's Name: _____
Approximate date of Last Visit: _____
Are you (or the patient) currently seeing this doctor for reasons other than routine check ups? If yes please let us know why:_____

Dentist's Name: _____
Approx date of Last Visit: _____ Approx date of Last Dental X-Rays: _____
Are you currently working with your dentist for reasons other than routine cleanings (gum disease, cavity control, etc):

_____

_____

SECTION B - WOMEN ONLY

	Yes	No	
1			Are you pregnant or anticipating being pregnant in the near future?
2			Are you taking birth control pills or hormones?

SECTION C - MEDICAL HISTORY

Yes No Please check as appropriate and write more information as needed

1			Do you need to be premedicated with antibiotics for any reason before dental procedures, cleanings, etc?
2			Heart murmur, congenital heart disease or any heart condition that requires antibiotics before dental procedure?
3			Heart trouble, heart attack, stroke, pacemaker, or prosthetic (artificial) heart valve?
4			High blood pressure?
5			Abnormal bleeding/hemophilia?
6			Seizures or convulsions?
7			Asthma, Emphysema, or difficulty breathing?
8			Diabetes (Type 1, Type 2 or pre-diabetes)?
9			Hepatitis, jaundice, or liver disease?
10			Osteoporosis/Osteopenia?
11			Arthritis?
12			Thyroid disease?
13			Have you had surgery or radiation treatment (x-ray) treatment for a tumor, growth, cancer, or other condition of your head, neck or mouth?
14			Cancer/Chemotherapy?
15			Do you have any hearing, visual problems, or other disabilities which we should consider in planning your dental treatment (e.g. glaucoma)?
16			Current speech therapy or history of speech therapy?
17			Anxiety?

18			Depression?
19			Sensory processing disorder?
20			Spectrum Diagnosis?
21			Any history of chewing tobacco, smoking or vaping any substance?
22			Any history of addiction or recovering from any drugs or alcohol?
23			If patient is a child, has he / she reached puberty?
24			Have you been hospitalized or had a serious illness during the past 5 years? If yes, what was the issue? Any other medical information not listed here? please write here:

SECTION D - MEDICATION QUESTIONS

HAVE YOU TAKEN ANY OF THE FOLLOWING DRUGS OR MEDICATIONS IN THE PAST 6 MONTHS?

	Yes	No	
1			Anticoagulants (blood thinners), or aspirin?
2			Medicine for high blood pressure or water pills?
3			Cortisone (steroids)?
4			Valium, Librium, or tranquilizers?
5			Ritalin, Adderall or similar type medications?
6			Growth hormone?
7			Insulin or pills for diabetes?
8			Digitalis or drugs for heart trouble?
9			Nitroglycerin or other medication for angina pectoris (chest or heart pain)?
10			Dilantin?
11			Medicine not prescribed by an M.D. (i.e. patent medicine)?
12			Osteoporosis medication (such as Boniva, Fosamax, Actonel, Reclast) ?
13			Other medications:

SECTION E- ALLERGIES

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION SUCH AS ITCHING, RASH,SWELLING OF HANDS, FEET OR EYES TO:

	Yes	No	
1			Penicillin or other antibiotics?
2			Latex, Nickel or other metals?
3			Aspirin?
4			Seasonal allergies?
5			Food allergies?
6			Others- please specify:

SECTION F - ORAL HEALTH

	Yes	No	
1			Have you consulted an orthodontist previously?
2			Have you received orthodontic care previously? If yes when and briefly describe treatment
3			Does anyone in the family have a strong lower jaw or similar dental or facial condition? If yes, please describe:
4			Are you aware of any teeth missing or extra teeth since birth?
5			Does anyone in the family have a history of missing teeth or extra teeth?
6			Is there a history of recurrent canker sores, mouth ulcers, or herpes infections?
7			Is there a history of fever blisters or cold sores ?
8			Is there a history of jaw joint pain, or any clicking or popping in the jaw joint? Please explain:
9			Have the teeth or jaws ever been injured in an accident? Please explain:
10			Are your teeth sensitive to cold, hot, sweet or pressure?
11			Do your gums bleed when you brush?

12			Have there been any problems with frequent dry mouth?
13			Are you aware of any oral habits such as thumb or finger habit, lip sucking, tongue thrust, grinding, nail biting, or chewing on foreign objects such as pencils?
14			Sleep apnea or snoring?
15			Have you ever been told that you have gum disease?
16			Are there any dental or TMJ issues, conditions, or problems not listed? Please specify:

I have read the above questions and understand them. The medical information provided is complete to the best of my knowledge. I will not hold my orthodontist or any member of their staff responsible for any errors or omissions that I have made in the completion of this form. I agree to inform this office of any changes in my medical or dental health.

Health questionnaire completed by (Print)_____ Date _____

Signature:_____ Date:_____
(Parent or guardian if patient is a minor)

Members American Association of Orthodontists