



# HEALTH HISTORY FORM

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
*Last First Middle*

Address \_\_\_\_\_  
*Street City State ZIP Code*

Home  Cell  Work Phone \_\_\_\_\_ Birth Date \_\_\_\_\_

Email: \_\_\_\_\_  Male  Female

## RESPONSIBLE PARTY INFORMATION

Name \_\_\_\_\_  
*Last First Middle Marital Status*

Relationship to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Email: \_\_\_\_\_

Residence \_\_\_\_\_  
SAME AS ABOVE  *Street City State ZIP Code*

Mailing Address \_\_\_\_\_  
SAME AS ABOVE  *Street City State ZIP Code*

How long at this address? \_\_\_\_\_  Home  Cell  Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
*Last First Middle*

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Birth Date \_\_\_\_\_  Home  Cell  Work Phone \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Name (First and Last) \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## PRIMARY INSURANCE

Subscriber's Name \_\_\_\_\_ Subscriber's Birth Date \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group Number \_\_\_\_\_

## SECONDARY INSURANCE

Subscriber's Name \_\_\_\_\_ Subscriber's Birth Date \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group Number \_\_\_\_\_

Signature (Parent's/Guardian's signature, if minor) \_\_\_\_\_ Date \_\_\_\_\_

*I understand that, where appropriate, credit bureau reports may be obtained.*

# HEALTH HISTORY

## I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand the question)

1. **YES NO** Is your general health good?
2. **YES NO** Has there been a change in your health within the last 3 years?
3. **YES NO** Have you been hospitalized or had a serious illness in the last 3 years?  
Why? \_\_\_\_\_
4. **YES NO** Are you being treated by a physician now?  
For what? \_\_\_\_\_ Date of last medical exam? \_\_\_\_\_
5. **YES NO** Are you seeing a general dentist?  
Who? \_\_\_\_\_ Phone: \_\_\_\_\_
6. **YES NO** Has patient ever sucked thumb or fingers? Until what age? \_\_\_\_\_
7. **YES NO** Does patient clench or grind teeth?
8. **YES NO** Does patient have pain or clicking upon opening/closing mouth?
9. **YES NO** Has the patient been examined by an orthodontist before? By Dr. \_\_\_\_\_ Date \_\_\_\_\_
10. **YES NO** Has the patient ever had orthodontic treatment?

## II. HAVE YOU EVER EXPERIENCED?

- |  |  |
|--|--|
| 10. <b>YES NO</b> Chest Pain (angina)?                     | 19. <b>YES NO</b> Ringing in ears?       |
| 11. <b>YES NO</b> Shortness of breath, asthma?             | 20. <b>YES NO</b> Headaches?             |
| 12. <b>YES NO</b> Recent weight loss, fever, night sweats? | 21. <b>YES NO</b> Fainting spells?       |
| 13. <b>YES NO</b> Persistent cough, coughing up blood?     | 22. <b>YES NO</b> Blurred vision?        |
| 14. <b>YES NO</b> Bleeding problems, bruising easily?      | 23. <b>YES NO</b> Seizures?              |
| 15. <b>YES NO</b> Sinus problems?                          | 24. <b>YES NO</b> Dry mouth?             |
| 16. <b>YES NO</b> Difficulty swallowing?                   | 25. <b>YES NO</b> Jaundice?              |
| 17. <b>YES NO</b> Frequent vomiting, nausea?               | 26. <b>YES NO</b> Joint pain, stiffness? |
| 18. <b>YES NO</b> Dizziness?                               |  |

## III. DO YOU HAVE OR HAD?

- |  |   |
|--|---|
| 27. <b>YES NO</b> Heart disease?                         | 38. <b>YES NO</b> Latex sensitivity?        |
| 28. <b>YES NO</b> Heart attack, heart defects?           | 39. <b>YES NO</b> Herpes?                   |
| 29. <b>YES NO</b> Heart murmur?                          | 40. <b>YES NO</b> Thyroid, adrenal disease? |
| 30. <b>YES NO</b> Rheumatic fever?                       | 41. <b>YES NO</b> Diabetes?                 |
| 31. <b>YES NO</b> Hepatitis, other liver disease?        | 42. <b>YES NO</b> Psychiatric care?         |
| 32. <b>YES NO</b> High blood pressure?                   | 43. <b>YES NO</b> Radiation treatments?     |
| 33. <b>YES NO</b> TB, emphysema, other lung disease?     | 44. <b>YES NO</b> Chemotherapy?             |
| 34. <b>YES NO</b> Osteoporosis or taken bisphosphonates? | 45. <b>YES NO</b> Stroke?                   |
| 35. <b>YES NO</b> AIDS or ARC?                           | 46. <b>YES NO</b> Diet medication?          |
| 36. <b>YES NO</b> Tumors, cancer?                        | 47. <b>YES NO</b> Prosthetic heart valve?   |
| 37. <b>YES NO</b> Arthritis, rheumatism?                 | 48. <b>YES NO</b> Pacemaker?                |

## IV. ARE YOU TAKING?

- |  |  |
|--|--|
| 49. <b>YES NO</b> Recreational drugs?              | 51. <b>YES NO</b> Tobacco in any form? |
| 50. <b>YES NO</b> Drugs, medicine, (incl aspirin)? | 52. <b>YES NO</b> Alcohol?             |

PLEASE LIST \_\_\_\_\_  
\_\_\_\_\_

## V. WOMEN ONLY: YES NO Are/could you be pregnant?

## VI. ALL PATIENTS: YES NO Do you have or have you had any other diseases/medical problems/allergies NOT listed on this form?

If yes, please explain: \_\_\_\_\_

*To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my health and/or medication.*

**Patient's/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_