

HEALTH QUESTIONNAIRE

Answers to the following questions are for our records only. Naturally they will be considered confidential and will become part of your permanent orthodontic record.

Please circle YES or NO to the following questions.

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| 1. Do you think that your teeth are affecting your general health in any way? | YES | NO |
| 2. Are you dissatisfied with the appearance of your teeth? | YES | NO |
| 3. Are you worried about receiving dental treatment? | YES | NO |
| 4. Do you have difficulty in chewing your food? | YES | NO |
| 5. Do you have sensitive teeth? | YES | NO |
| 6. Do you have bleeding gums? | YES | NO |
| 7. Have you ever had sores in the mouth or on the lips that are slow to heal? | YES | NO |
| 8. Do you have difficulty in opening your mouth wide? | YES | NO |
| 9. Do you now have or have you ever had sinus trouble? | YES | NO |
| 10. Have you ever have any injury to your face or jaws? | YES | NO |
| 11. Have you been examined by your physician within the last year? | YES | NO |
| 12. Are you being treated for any condition by a physician now? | YES | NO |
| 13. Have you been taking any medicines within the past year? | YES | NO |
| 14. Has there been any change in your general health in the past year? | YES | NO |
| 15. Have you lost or gained weight in recent months? | YES | NO |
| 16. Have you ever been seriously ill? | YES | NO |
| 17. Have you ever been hospitalized? | YES | NO |
| 18. Have you ever had surgery (an operation)? | YES | NO |
| 19. Have you ever had a blood transfusion? | YES | NO |
| 20. Have you ever had x-ray or surgery treatment for tumor, growth, or other conditions about your head, mouth, or on your lips? | YES | NO |

21. Have you ever been treated for a growth or tumor in any other part of your body? YES NO

22. Are you frequently ill? YES NO

23. Do you often feel exhausted or fatigued? YES NO

24. Have you ever had any of the following diseases or conditions:

A. Jaundice (yellow skin/eyes)	YES	NO	I. Diabetes	YES	NO
B. Hepatitis	YES	NO	J. Measles	YES	NO
C. Tuberculosis	YES	NO	K. Chicken Pox	YES	NO
D. Venereal Disease	YES	NO	L. Mumps	YES	NO
E. Heart Attack	YES	NO	M. Polio	YES	NO
F. Stroke	YES	NO	N. Rheumatic	YES	NO
G. Ulcers	YES	NO	Fever		
H. Epilepsy	YES	NO	O. Scarlet Fever	YES	NO

25. As a child, did you have growing pains or twitching of the limb? YES NO

26. Have you ever had painful or swollen joints? YES NO

27. Have you ever been told by a physician that you have a heart murmur? YES NO

28. Do you now or have you ever had any heart trouble? YES NO

29. Do you have high blood pressure? YES NO

30. Do you bleed for a long time when you cut yourself? YES NO

31. Do you bruise easily? YES NO

32. Do you have any blood disorder such a anemia (thin blood)? YES NO

33. Do you have any chest pain or exertion? YES NO

34. Are you ever short of breath or mild exertion? YES NO

35. Do your ankles ever swell? YES NO

36. Do you have a persistent cough? YES NO

37. Do you have or have you ever had asthma? YES NO

38. Do you ever have hay fever? YES NO

39. Do you have any allergies (food, animals, dust, etc.)? YES NO

40. Do you ever have hives or skin rashes? YES NO

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| 41. Have you ever experienced an unusual reaction to any of the following drugs: | | | | | | | |
| A. | Penicillin | YES | NO | D. | Iodine | YES | NO |
| B. | Barbiturates | YES | NO | E. | Sulfa Drugs | YES | NO |
| C. | Aspirin | YES | NO | F. | Other Medicines | YES | NO |
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42. Have you ever experienced an unusual reaction to a dental anesthetic (Novocain Injection)?
43. Do you often have to get up at night to urinate?
44. During the day, do you usually have to urinate frequently?
45. Are you thirsty much of the time?
46. Has a doctor ever said you had kidney/bladder disease or infection?
47. Has a doctor ever said you had liver disease?
48. Do you have any numbness or tingling in any part of your body?
49. Has any part of your body ever been paralyzed?
50. Do you ever have fits or convulsions?
51. Do you have a tendency to faint?
52. Do you have frequent severe headaches?
53. Do you consider yourself to be a nervous person?
54. Do you suffer from severe nervous exhaustion?
55. Do you often feel unhappy and depressed?
56. Do you often cry?
57. Are you easily upset or irritated?
58. Women -- Are you pregnant at the present time?
59. Women -- Are you in or have you passed through menopause (change of life)?
60. Women -- Have you had a hysterectomy or ovariectomy?

Patient/Parent Signature

Date