

Medical Questionnaire

Patient's Physician: _____

Address: _____

Patient's general health: Excellent Good Fair Poor

Please list any and all previous illnesses, hospitalizations or serious medical conditions: _____

Please list any **allergies**: _____

Are you currently taking any medications (pills, drugs, injections, etc.)? Please list them here: _____

Has the patient ever taken intravenous bisphosphonates such as: Zometa, Aredia or Didronel? Yes No

Has the patient ever taken oral bisphosphonates such as: Fosamax, Actonel, Boniva, Skelid or Didronel? Yes No

Has the patient ever taken other bone antiresorptive medication? Yes No If yes, check all that apply:

Denosumab (Prolia®) Calcitonin (Miacalcin®, Fortical®) Teriparatide (Forteo) Raloxifene (Evista®)

If female, are you pregnant or is there any possibility that you might be pregnant? Yes No

Do you presently have or have you **ever had** any of the following?

- | | | | | | |
|---------------------------------|----------------------------------------------------|--------------------------------------|----------------------------------------------------|---------------------------------------|----------------------------------------------------|
| Anemia..... | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy/Seizures/Fainting spells .. | <input type="radio"/> Yes <input type="radio"/> No | Kidney Disease..... | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis..... | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease..... | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial bone/joints..... | <input type="radio"/> Yes <input type="radio"/> No | Gonorrhea..... | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse..... | <input type="radio"/> Yes <input type="radio"/> No |
| Adenoids/Tonsils removed | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever..... | <input type="radio"/> Yes <input type="radio"/> No | Pneumonia..... | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma..... | <input type="radio"/> Yes <input type="radio"/> No | Heart Disease..... | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric/Learning Disability | <input type="radio"/> Yes <input type="radio"/> No |
| AIDS or HIV+ | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur..... | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever..... | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disorders | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia/ Abnormal Bleeding.. | <input type="radio"/> Yes <input type="radio"/> No | Sinus/Breathing Problems..... | <input type="radio"/> Yes <input type="radio"/> No |
| High/Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Herpes..... | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer/Chemotherapy/Radiation.. | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis..... | <input type="radio"/> Yes <input type="radio"/> No | Syphilis..... | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores | <input type="radio"/> Yes <input type="radio"/> No | Hives..... | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis/TB..... | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Jaundice | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |

Other _____

Initials: _____

DENTAL HISTORY

Explain the nature of the problem in your own terms. Why do you think you may benefit from orthodontic treatment?

Whom may we thank for referring you to our office?

Who suggested you might benefit from orthodontic treatment?

Your Dentist A Family Member A Friend The School Other

Were you aware of any orthodontic problems prior to the referral? _____

Have you ever had orthodontic treatment? Yes No If so, when? _____

Name of your dentist _____

Last visit to dentist was on _____ for _____

Dentist's Address _____

Do you grind or clench your teeth? Yes No

Does your jaw "click, crack or pop" upon opening or closing? Yes No

Do you have pain in the lower jaw upon opening or closing? Yes No

Do you have TMJ dysfunction? Yes No

Have you ever had any speech problems or any speech therapy? Yes No

Have you had any medical problems associated with dental treatment before? Yes No

Have you ever had any trauma to your mouth/teeth/face? Yes No

Do you primarily breathe through your mouth? Yes No

Do you snore? Yes No

Do you brush your teeth daily? Yes No

Do you floss daily? Yes No

Does the patient's physician recommend medication for a preexisting condition before any dental procedure? Yes No

Initials: _____

Medical Questionnaire

Patient's Physician: _____

Address: _____

Patient's general health: Excellent Good Fair Poor

Please list any and all previous illnesses, hospitalizations or serious medical conditions: _____

Please list any **allergies**: _____

Are you currently taking any medications (pills, drugs, injections, etc.)? Please list them here: _____

Has the patient ever taken intravenous bisphosphonates such as: Zometa, Aredia or Didronel? Yes No

Has the patient ever taken oral bisphosphonates such as: Fosamax, Actonel, Boniva, Skelid or Didronel? Yes No

Has the patient ever taken other bone antiresorptive medication? Yes No If yes, check all that apply:

Denosumab (Prolia®) Calcitonin (Miacalcin®, Fortical®) Teriparatide (Forteo) Raloxifene (Evista®)

If female, are you pregnant or is there any possibility that you might be pregnant? Yes No

Do you presently have or have you **ever had** any of the following?

- | | | | | | |
|--------------------------------|----------------------------------------------------|--------------------------------------|----------------------------------------------------|---------------------------------------|----------------------------------------------------|
| Anemia..... | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy/Seizures/Fainting spells .. | <input type="radio"/> Yes <input type="radio"/> No | Kidney Disease..... | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis..... | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease..... | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial bone/joints..... | <input type="radio"/> Yes <input type="radio"/> No | Gonorrhea..... | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse..... | <input type="radio"/> Yes <input type="radio"/> No |
| Adenoids/Tonsils removed | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever..... | <input type="radio"/> Yes <input type="radio"/> No | Pneumonia..... | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma..... | <input type="radio"/> Yes <input type="radio"/> No | Heart Disease..... | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric/Learning Disability | <input type="radio"/> Yes <input type="radio"/> No |
| AIDS or HIV+ | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur..... | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever..... | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disorders | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia/ Abnormal Bleeding.. | <input type="radio"/> Yes <input type="radio"/> No | Sinus/Breathing Problems..... | <input type="radio"/> Yes <input type="radio"/> No |
| High/Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Herpes..... | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer/Chemotherapy/Radiation. | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis..... | <input type="radio"/> Yes <input type="radio"/> No | Syphilis..... | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores | <input type="radio"/> Yes <input type="radio"/> No | Hives..... | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis/TB..... | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Jaundice | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |

Other _____

Initials: _____

EPWORTH SLEEPINESS SCALE: how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W Johns, Sleep 1991)

0 = would never doze | 1 = slight chance of dozing | 2 = moderate chance of dozing | 3 = high chance of dozing

Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive, in a public place (theater, meeting, etc.)	0	1	2	3
As a passenger in a car for an hour without break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Epworth Score
TOTAL the values from all 8 questions.
If 11 or less
Score= 0
If 12 or more
Score= 2

HABITS	Never	Rarely 0-1 times/wk	Sometimes 1-2 times/wk	Frequently 3-4 times/wk	Always 5-7 times/wk
On average in the past month, how often have you snored or been told that you snore?	<input type="checkbox"/> +0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3	<input type="checkbox"/> +4
Do you wake up choking or gasping?	<input type="checkbox"/> +0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3	<input type="checkbox"/> +4
Have you ever been told that you stop breathing in your sleep or wake up choking or gasping?	<input type="checkbox"/> +0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3	<input type="checkbox"/> +4
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	<input type="checkbox"/> +0	<input type="checkbox"/> +0	<input type="checkbox"/> +0	<input type="checkbox"/> +0	<input type="checkbox"/> +4

Habits Score
TOTAL the values from all answers from first 3 habits

AUTHORIZATIONS

I authorize the release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

I certify that the above information is accurate and understand that an appropriate credit bureau report may be obtained.

I have read the above questions and understand them. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form.

I will notify my orthodontist of any changes in my medical or dental history.

Signature: _____ Date: _____