Questionnaire

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Halgren Medical Dental History Form

Medical Dental History Form For Patients 18 years of Age or Older.

Halgren Orthodontics
Medical Dental History Form (Adult)

For the Following questions mark Yes, No The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient's First Name:

Patient's Middle Initial:

Patient's Last Name:

Preferred Name

Birth Date:

Sex:

Male	Female	Other{}
Non-binary	Transgender	Other{}

Identifying Pronoun

She/her	He/him	They/them
Other{}		

Primary Language

English	Spanish	Other {}

Home Phone Number:

Cell Phone Number:

Email Address:

Patient's Address (both physical & PO Box):

City:

State/ Province:

Zip/ Postal Code:

Years at Above Address:

If less than 5 years at current address, previous address:

Patient Status:

Single	Married	Other{}

Occupation:

Employer:

Years with Employer:

Name of Spouse/ Significant Other

Phone Number (if different than yours):

Spouse's-Significant Other's Occupation

Employer

Years with Employer:

Name of Patient's Dentist:

{}

Date of Last Cleaning:

What do you want to change about your smile?

Who can we thank for the referral?

INSURANCE INFORMATION

Yes No

Insurance Coverage For Orthodontic Treatment?

Yes No Unknown

Primary Policy Holder's Name:

Dental Insurance Company (copy of insurance card appreciated)

ID Number-SS Number

{}

Birth Date:

Secondary Policy Holder's Name:

Dental Insurance Company:

ID Number-SS Number:

Birth Date:

Medical History

Now or in the past, have you had:

Heart Conditions-Mark any that apply to you

Heart murmur
Chest pain
High or Low Blood pressure problems
Heart Valve problem
Taking heart medication
Rheumatic Fever
Pacemaker
Artificial heart valve
Pre-dental treatment antibiotic necessary

Blood pressure - Mark any that apply to you

Easy bruising
Frequent nosebleeds
Abnormal bleeding
A blood transfusion
Blood Disease
Anemia

Allergy Conditions - Mark any that apply to you

Hay Fever
Sinus problems
Skin Rashes
Taking allergy medication
Asthma

Intestinal Conditions - Mark any that apply to you

Ulcers
Weight gain or loss
Special diet
Constipation/Diarrhea
Kidney or bladder problems

Bone or joint Conditions - Mark any that apply to you

Arthritis
Osteoporosis
Joint replacement
Pre-dental treatment antibiotic necssary

Fainting spells, seizures or epliepsy

Yes No

Stroke

Yes No

Frequent headaches, colds or sore throats

Yes No

Thyroid problems

Yes No

Persistent cough

Yes No

Pre-medications required by physician

Yes No

Cancer/Tumor/Radiation treatment

Yes No Type {}
Location {}

Diabetes

Yes	No	Type I
Type II		

Tuberculosis or other lung disease

Yes	No	

Do you smoke, vape, or chew?

Yes	No	Nicotine?
Marijuana?	Daily	Occasionally

Hepatitis or liver trouble

Yes	No	

Herpes or other STD

Yes	No	

HIV-positive/AIDS

Yes	No	

Immune system problems

Yes	No	If yes, please list:{}

Tonsil or Adenoid conditions

Yes	No	

Has the patient reached puberty?

Yes	No	

Women-Are you pregnant or trying to become pregnant?

Yes	No	

Does the patient have allergies or reactions to any of the following:

Latex (gloves, balloons)	Metals (jewelry, clothing snaps)	Acrylics
Local anesthetics (novocaine, lidocaine, xylocaine)	Aspirin	Ibuprofen (Motrin, Advil)
Penicillin	Plant Pollens	Animals
Foods	Other substances: {}	Other Antibiotics {}

Any disease, problems, or conditions not listed (Example..ADHD):

{}

List medications currently taking and for what condition:

{}

DENTAL HISTORY - Now or in the past has the patient had:

Permanent or "extra" teeth removed	Extra or congenitally missing teeth	Teeth sensitive to hot/cold
Jaw fractures, cysts, or mouth infections	Periodontal/Gum problems	Thumb, finger, or sucking habit
Tongue thrusting habit	Mouth breathing habit or snoring	Sleep Apnea
Tooth grinding or jaw clenching	Pain, clicking, or locking of the jaw joint	Pain or soreness in muscles of face
Difficulty in chewing any food	Treatment for TMD or TMJ problems	A relative with similar tooth/jaw problems
A prior orthodontic exam or treatment	Speech therapy	Dead teeth or root canals (necrotic)
Has either parent had braces or ortho treatment		

Emergency Contact-Person outside household

Name {}	Relationship to patient {}	Phone number {}