Questionnaire

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Halgren Medical Dental History Form (Child)

Medical Dental History Form For Patients 17 years of Age or Older Younger

Halgren Orthodontics
Medical Dental History Form (Child)

For the following questions mark Yes or 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	Non-binary
Transgender	Other{}	

Identifying Pronoun

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

Primary Language

English	Spanish	Other {}

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

City:

State/ Province:

Zip/ Postal Code:

Child's School:

{}

Musical Instruments Played:

{}

Sports And/Or Hobbies:

{}

Number of Brothers and Sisters

{}

Who does the child live with:

Mom and Dad	Mom	Dad
Other:{}		

Mother's Name

{}

Mother's Address (if different than child)

{}

Mother's Birth Date

Mother's cell number and email address

{}

Mother's Employer and Number of Years Employed

{}

Mother's Occupation

{}

Father's Name

{}

Father's address (if different than child)

{}

Father's Birth Date

Father's cell number and email address

{}

Father's Employer and Number of Years Employed

{}

Father's Occupation

{}

Does child follow directions well?

{}

Does child brush his/her teeth consistently?

{}

Does the child have learning disabilites or need extra help with instructions?

{}

Is patient sensitive or self-conscious about teeth?

{}

Does the child have any dental anxiety?

{}

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

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	Osteopetrosis	

Fainting spells, seizures or epliepsy

Yes | No

Stroke

Yes | No

Frequent headaches, colds or sore throats

Yes | No

Thyroid conditions

Hyperthyroidism | Hypothyroidism | Other {}

Persistent cough or Lung Disease

Yes | No | {}

Pre-medications required by physician

Yes | No

Cancer/Tumor/Radiation treatment

Yes | No | Type {}

Location {}

Diabetes

Yes | No | Type I

Type II

Smoke, vape, or chew?

Yes	No	Daily
Occasionally	Marijuana	Nicotine

Hepatitis or liver disease

Yes | No | If yes, {}

Herpes or other Sexually Transmitted Disease

Yes | No | If yes:{}

HIV-positive/AIDS

Yes | No

Immune system conditions

Yes | No | If yes, please list:{}

Tonsil or Adenoid conditions

Yes | No

Development Disorders

ADHD | Autism | Other {}

Has the patient reached puberty?

Yes | No

Women-Are you pregnant or trying to become pregnant or breastfeeding?

Yes | No | If yes:{}

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 or conditions not listed:

{}

List medications currently taking and for what condition:

None

List meds:{}

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 orthodontic treatment	Trauma to jaw or face	

Emergency Contact-Person outside household

Name {}

Relationship to patient {}

Phone number {}