Dailey Orthodontics

G. Curtis Dailey, D.D.S.

Health History Questionnaire

Patient's Name: _____ Sex: M ☐ F ☐ Birthdate: _____

Address: _____ Phone: _____

Please bring any insurance forms or information you may have to your next appointment. Thank you.

INSTRUCTIONS:

1. Please complete the data requested above.
2. Please answer every question requested below, indicating a ☐ NO if not applicable.
3. If you answer ☐ YES, please check off any "specifics" of the problem and "Please Explain. . ." any specifics along with any medication and it's dosage for the problem, if applicable.
4. Please sign and date the back page bottom, and bring this form with you to your appointment.

MEDICAL HISTORY for (Name): _____

What is the name of your family physician? _____ Date of your last visit to this physician: _____

Are there any Medical Specialists you see regulary? _____ Specialty: _____

When was the last time you had a complete physical exam? Date _____ Examining doctor's name: _____

What is your approximate height: _____ feet, _____ inches. What is your approximate weight: _____ pounds. Body Frame Size: Small☐ Medium☐ Large☐

History of:		Specifics of Problems if *YES*	*Please Explain...Also indicate any Medication (& dosage)*
Head/Neck Problems?	NO ☐ **YES** ☐	Headaches: Migraine☐ Sinus☐ Eyes☐ Temples☐ Back of head☐ Painful Scalp☐ Neck Pain☐ Lumps in Neck☐ Tired/Sore Neck Muscles☐	
Neural Problems?	NO ☐ **YES** ☐	Epilepsy☐ Seizures☐ Numbness/Tingling☐ Other☐	
Eye Problems?	NO ☐ **YES** ☐	Pain☐ Bloodshot☐ Blurred Vision☐ Pressure on Eyeballs☐ Light Sensitivity☐ Watery☐ Drooping Eyelids☐ _____	
Ear Problems?	NO ☐ **YES** ☐	Pain☐ Clogged☐ Hissing☐ Ringing☐ Dizziness☐ Nausea☐ Loss of Hearing Volume☐ Loss of Balance☐	
Nose/Sinus Problems?	NO ☐ **YES** ☐	Obstruction☐ Stuffiness☐ Runny Nose☐ _____	
Throat Problems?	NO ☐ **YES** ☐	Sore Throat☐ Swallowing Difficulties☐ Lump in Throat☐ Laryngitis☐ Voice Fluctuations☐ Tongue Pain☐ Persistent Coughing/Clearing Throat☐	
Breathing Problems?	NO ☐ **YES** ☐	Asthma☐ Wheezing☐ Shortness of Breath☐ Chronic Cough☐ Cough up Blood/Sputum☐	
Back, Shoulder, Extremity Problems?	NO ☐ **YES** ☐	Aching Shoulders☐ or Stiffness☐ Lack of Mobility☐ Upper☐ Lower☐ Back Pain☐ Numbness in Arms☐ Cramps in Legs: When Waking☐ At Night☐	
Bone Problems?	NO ☐ **YES** ☐	Break easily☐ Pain☐ Arthritis☐ Joint Pain☐ Joint Swelling☐	
Heart Problems?	NO ☐ **YES** ☐	Coronary Heart Disease☐ Heart Valve Disease☐ High Blood Pressure☐ Chest Pain☐ Angina☐ Heart Murmur☐ Irregular Heartbeat☐ Palpitations☐	
Urinary System Problems?	NO ☐ **YES** ☐	Urgency☐ Painful Urination☐ Frequent Urination☐ Nighttime Urination☐ Release when Sneeze/Cough☐ Blood in Urine☐ Kidney Infection☐	
Stomach & Intestine Problems?	NO ☐ **YES** ☐	Ulcers☐ Bleeding☐ Abdominal Pain☐ Heartburn☐ Nausea/Vomiting☐ Constipation☐ Diarrhea☐ Gall Bladder Disease☐ Intestinal Disease☐ Black Stool☐ Intolerance to: Milk☐ Eggs☐	
Endocrine Problems?	NO ☐ **YES** ☐	Pancreas☐ Thyroid☐ Pituitary☐ _____	

History of:		Specifics of Problems if *YES*	*Please Explain...Also Indicate any Medication (& dosage)*
Liver Problems?	NO ☐ **YES** ☐		
Kidney Problems?	NO ☐ **YES** ☐		
Blood Problems?	NO ☐ **YES** ☐	Hemophilia☐ Anemia☐ Bruise Easily☐ Bleed Easily☐ Blood Clots☐ Had Stroke☐	
Chronic Disease Problems?	NO ☐ **YES** ☐	Diabetes☐ Cancer☐ Hepatitis A☐ B☐ Tuberculosis☐ Infectious Diseases☐ Swelling☐ Tonsilitis☐ Excessive Colds☐	
Skin Problems?	NO ☐ **YES** ☐	Eczema☐ Dry☐ Oily☐ Itchy☐	
One Time Problems?	NO ☐ **YES** ☐	Mumps(@ age _____) Rheumatic Fever(@ age _____) Measles(@ age _____) Chicken Pox(@ age _____)	
Heart Surgery?	NO ☐ **YES** ☐	Heart Valve(date _____) Pacemaker(date _____) Bypass(date _____) _____ (date _____)	
Other Surgery?	NO ☐ **YES** ☐	Tonsils(date _____) Adneoids(date _____)	
Serious Surgery?	NO ☐ **YES** ☐	Broken Bones(date _____) _____	
Occupational Disease?	NO ☐ **YES** ☐ (Adults)		

Family History of:		If Yes, Which Family Members:	Comments on Family History of Diseases:
Diabetes?	NO ☐ **YES** ☐		
Cancer or Skin Cancer?	NO ☐ **YES** ☐		
Tuberculosis?	NO ☐ **YES** ☐		
Heart Disease?	NO ☐ **YES** ☐		
High Blood Pressure?	NO ☐ **YES** ☐		
Organ Disease?	NO ☐ **YES** ☐		
Kidney Disease?	NO ☐ **YES** ☐		
Lung Disease?	NO ☐ **YES** ☐		
Emotional Problems?	NO ☐ **YES** ☐		
Stroke?	NO ☐ **YES** ☐		
Arthritis?	NO ☐ **YES** ☐		

Habit Excesses?	NO ☐ **YES** ☐	Smoking (_____Packs Day) for _____ years Caffeine☐ Alcohol☐ Over Eating☐
Exercise Regularly?	NO ☐ **YES** ☐	_____ Hours/Day☐ Week☐ Month☐
Psychological Problems?	NO ☐ **YES** ☐	Anxiety☐ Depression☐ Psychiatric Disorder☐ Insomnia☐ _____
Presently Taking Medication?	NO ☐ **YES** ☐ (Dosage)	Birth Control☐ Diuretics☐ Blood Pressure☐ Blood Thinners☐ Heart☐ Tranquilizers☐
Allergic Reactions?	NO ☐ **YES** ☐	Hay Fever☐ To Foods☐ To Metals/Plastics☐
Drug Reactions?	NO ☐ **YES** ☐	Anti-Bacterial Drugs☐ _____
Anesthetic Reaction?	NO ☐ **YES** ☐	Local Anesthetic☐ General Anesthetic☐
Are you HIV Positive?	NO ☐ **YES** ☐	

Please indicate anything else we should know about the present state of your health, not mentioned above (High Cholesterol, etc. levels):

I hereby certify that I have reviewed the above material and that it is accurate to my knowledge at this time. If there are any future changes in this information, I will notify Dr. Dailey's Office.

Signature of Person Filling Out This Health History	**Date this history was completed**	**Signature of the T.C. who reviewed this health history**
Signature that the examination **DOCTOR** reviewed this history	**Date** of the interview and **DOCTOR** review of this history	**Date** above T.C. reviewed this health history

Dailey Orthodontics
G. Curtis Dailey, D.D.S.
Dental History

Patient Name: _____

Name of Your Family Dentist: _____ Date of your last visit to this dentist: _____

Dental Specialists who have Treated you (Give Names, Treatments & Dates): _____

Other Orthodontists or Dental Specialists who have treated you: _____

How Many times per day do you ***BRUSH*** your teeth? 0☐ 1☐ 2☐ 3+☐ How many times per day do you ***FLOSS*** your teeth? 0☐ 1☐ 2+☐

History Of:		Specifics of Problems if YES:	Please Explain any YES answers
Tooth Injury?	NO☐ **YES**☐	Chipped☐ Broken☐ Lost☐	_____
Oral Disease?	NO☐ **YES**☐	Ulcers☐ Sores☐	_____
Jaw Joint Pain?	NO☐ **YES**☐	Right T.M.J.: Constant☐ Periodic☐ When You: Chew☐ Yawn☐ Talk☐ Open Wide☐	
		Left T.M.J.: Constant☐ Periodic☐ When You: Chew☐ Yawn☐ Talk☐ Open Wide☐	
		Comments: _____	
Jaw Joint Noises?	NO☐ **YES**☐	**Right** T.M.J.: Click☐ Popping☐ Grating☐ _____	
	NO☐ **YES**☐	**Left** T.M.J.: Click☐ Popping☐ Grating☐	
Jaw Joint Locking?	NO☐ **YES**☐	**Right** T.M.J.: When Open☐ When Closed☐ _____	
	NO☐ **YES**☐	**Left** T.M.J.: When Open☐ When Closed☐ _____	
Grinding Your Teeth?	NO☐ **YES**☐	During the Day☐ _____ _____	
		When Sleeping☐ _____ _____	
Clenching Your Teeth?	NO☐ **YES**☐	During the Day☐ _____ _____	
		When Sleeping☐ _____ _____	
Bleeding Gums?	NO☐ **YES**☐	Usually☐ Sometimes☐ Rarely☐ _____	
		When Brushing☐ Flossing☐ Eating☐ _____	
Oral Habits?	NO☐ **YES**☐	Thumb Sucking☐ Finger Sucking☐ _____	
		Tongue Thrusting☐ Nail Biting☐ _____	
Other Oral Problems?	NO☐ **YES**☐	If YES, please explain: _____	
		_____	
		_____	
		_____	

Have you ever had:

Periodontal (gums) Treatment?	NO☐ **YES**☐	What kind of treatment? _____
Orthodontic (braces) Treatment?	NO☐ **YES**☐	What kind of treatment? _____
Endodontic (root canal) Treatment?	NO☐ **YES**☐	What kind of treatment? _____
Oral Surgery (jaw surgery) Treatment?	NO☐ **YES**☐	What kind of treatment? _____
Prosthodontic (crown & bridge) Treatment?	NO☐ **YES**☐	What kind of treatment? _____

I hereby certify that I have reviewed the above material and that it is accurate to my knowledge at this time. If there are any future changes in this information I will notify Dr. Dailey's Office.

_____ _____

Signature of Person Filling Out This Dental History ➡ Date this history was completed

_____ _____

Signature that the examination DOCTOR reviewed this history ➡ Date of interview and DOCTOR review of this history

_____

Signature of the T.C. who reviewed this dental history

_____

Date above T.C. reviewed this dental history