TINGEY orthodontics

Health History Questionaire (Confidential)

Name_____ **DOB**_____

1. Have you ever had any health problems in the past five (5) years?..... Yes No
2. Have you seen a physician or other health care provider in the past two (2) years?..... Yes No
3. Is there any activity your doctor says you cannot do?..... Yes No
4. Have you been hospitalized or had a serious illness in the past five (5) years?..... Yes No
5. Have you ever had a bleeding problem?..... Yes No

Please circle the appropriate response if you have ever had the following. If you are not sure, do not answer the question.

Heart / Blood Vessels

Rheumatic fever..... Yes No
Rheumatic heart disease..... Yes No
Heart valve damage..... Yes No
Heart murmur..... Yes No
Congenital heart defect..... Yes No
Artifical heart valve..... Yes No
Prolapsed heart valve..... Yes No
High blood pressure..... Yes No
Heart attack (Date_____)..... Yes No
TIA/Stroke (Date_____)..... Yes No
Heart Surgery (Date_____)..... Yes No
Vascular Surgery (Date_____). Yes No
Pacemaker..... Yes No
Coronary Heart Disease..... Yes No
Congestive heart failure..... Yes No
Angina pectoris/chest pain..... Yes No
Irregular/rapid heart beats..... Yes No
Other heart or vessel disorder... Yes No

Blood

Blood clots or thrombosis..... Yes No
Anemia..... Yes No
Sickle cell disease / trait..... Yes No
Hemophilia..... Yes No
Transfusion (Date_____)..... Yes No
Bruise easily for no apparent reason..... Yes No
Other blood disorder..... Yes No

Nervous System

Epilepsy..... Yes No
Siezure disorder..... Yes No
Multiple sclerosis..... Yes No
Trigeminal neuralgia..... Yes No
Chronic pain..... Yes No
Anxiety/depression..... Yes No
Alzheimer's disease/dimentia.... Yes No
Psychiatric treatment..... Yes No
Psychological counseling..... Yes No
Persistent dizziness/fainting spells..... Yes No
Persistent numbness/tingling.... Yes No
Other nervous system/mental disorder..... Yes No

Head and Neck

Glaucoma..... Yes No
Chronic sinusitis..... Yes No
Injury to head, neck, jaw or teeth..... Yes No
Headaches..... Yes No
Unexplained visual change..... Yes No
Frequent or severe nosebleeds. Yes No
Persistent sore throat or hoarseness..... Yes No
Recurrent neckache or neck pain..... Yes No
Recent difficulty swallowing..... Yes No
Other head or neck disorder..... Yes No

Endocrine

Diabetes..... Yes No
Low thyroid..... Yes No
Other thyroid condition..... Yes No
Cushings syndrome..... Yes No
Parathyroid condition..... Yes No
Other endocrine condition..... Yes No

Musculoskeletal / Connective

Sjögren's syndrome..... Yes No
Arthritis..... Yes No
Artificial joint (Date_____)..... Yes No
Fibromyalgia/rheumatism..... Yes No
Chronic back pain..... Yes No
Other muscle or bone disorder.. Yes No

Respiratory

Tuberculosis (TB)..... Yes No
Asthma..... Yes No
Chronic bronchitis..... Yes No
Emphysema..... Yes No
Persistent cough..... Yes No
Cough up bloody sputum..... Yes No
Shortness of breath..... Yes No
Other respiratory disorder..... Yes No

Urinary Tract

Kidney disease..... Yes No
Renal dialysis..... Yes No
Venereal disease..... Yes No
Sexually transmitted disease..... Yes No

Digestive System

Hepatitis..... Yes No
Cirrhosis of the liver/liver disease..... Yes No
Ulcers..... Yes No
Jaundice..... Yes No
Frequent Heartburn or reflux..... Yes No
Frequent nausea/vomiting..... Yes No
Other digestive disorder..... Yes No

Cancer History

Cancer..... Yes No
If yes, type?_____
Leukemia..... Yes No
Benign tumors/growths..... Yes No
Type of treatment
Surgery..... Yes No
Radiation therapy..... Yes No
Chemotherapy..... Yes No
Hormone therapy..... Yes No

Allergy History

Are you alergic to or have you ever had a bad reaction to any of the following?

Dental Anesthetics..... Yes No
Penicillin..... Yes No
Sulfa drugs..... Yes No
Other antibiotics..... Yes No
Aspirin..... Yes No
Latex products..... Yes No
Metals, including jewelry..... Yes No
Other allergy..... Yes No

Family History

Has anyone in your family (grandparent, parent, sibling, child) ever had:
Diabetes..... Yes No
Heart disease..... Yes No
Depression or anxiety..... Yes No
Tuberculosis..... Yes No
Any disorder that "runs in" your family..... Yes No

TINGEY orthodontics

Health History Questionaire (Confidential, continued)

Dental

Difficulty opening jaw..... Yes No
TMD or TMJ problems..... Yes No
Extra or missing teeth..... Yes No
Chipped primary/adult teeth..... Yes No
Sensitive teeth (hot/cold)..... Yes No
Jaw Fractures / Cysts..... Yes No
Dead teeth / root canals..... Yes No
Bleeding gums / bad taste..... Yes No
Periodontal problems..... Yes No
Food impaction
between teeth..... Yes No
Frequent canker/cold sores..... Yes No
Finger/thumb sucker..... Yes No
Age? _____
Abnormal swallowing.....
Speech problems..... Yes No
Snoring / mouth breathing..... Yes No
Jaw clenching or
teeth grinding..... Yes No
Ringing in ears..... Yes No
Jaw locking/clicking..... Yes No
Previous treatment problems.... Yes No
Tonsil/adenoid conditions..... Yes No

Miscellaneous

Lupus erythematosus..... Yes No
Organ transplant..... Yes No
If yes, which?_____
Supressed immune system..... Yes No
Persistent fever..... Yes No
Taken steroid/prednisone..... Yes No
Taken prescription diet pills..... Yes No
If yes, type?
Pondimin..... Yes No
Redux..... Yes No
Phen-fen..... Yes No
Other_____
Used tobacco products Yes No
If yes, type?_____
How much?_____
How long?_____
Still using..... Yes No
Would like to quit..... Yes No
Quit on (Date_____)
Drink alcoholic beverages..... Yes No
How much?_____
Used methamphetamine
amphetamines/"speed"... Yes No
Used intravenous drugs..... Yes No
Used cocaine or "crack"..... Yes No
Used any other recreational
drug..... Yes No
Are you a recovering alcoholic

Miscellaneous cont.

Birth defects..... Yes No
Aids/HIV Positive..... Yes No
Bone Fractures..... Yes No
Skin Disorders..... Yes No

Women Only

Started menstruation?..... Yes No
Are you pregnant or is there
a chance you may
be pregnant?..... Yes No
Are you breast feeding?..... Yes No
Are you in or have you
passed through
menopause?..... Yes No

Do you have any other condition that you think we should know about?... Yes No

_____

Please circle all the medications you are currently taking:

Heart	Blood Thinners	Hormones	Antibiotics
Nitroglycerin	Blood Pressure	Insulin/diabetic drugs	Antihistamine
Digitalis	Oral Contraceptive	Thyroid	Cyclosporin A
Aspirin(__tab/day)	Steroids/Cortisone	Nifedipine	
Tranquilizers	Antidepressants	Pain	

Please list medication names and dosages

Name	**Dosage**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have read and understand the above questions. I will not hold my orthodontist or his staff responsible for any errors or omissions I have made in the completion of this form. If there are any medical/dental changes in the future, I will inform this office.

_____ _____
Signature of Patient, Parent, or Guardian Date

_____ _____
Brent J. TIngey, DMD, MS Date