

INFORMATION FORM FOR CHILDREN

Date _____

DAVID D. FEUER, D.D.S., P.A.
www.orthodonticsmiles.com

P. O. BOX 1626
1708 N. FEDERAL HIGHWAY
LAKE WORTH, FL 33460
(561) 588-0319

685 ROYAL PALM BEACH BLVD.
SUITE 202
ROYAL PALM BEACH, FL 33411
(561) 790-0319

HISTORY QUESTIONNAIRE

Please do not write in spaces below

Patient's Name _____ Birthdate _____ Age _____

Patient's Address _____ City _____ Zip _____

Home Telephone _____ Nickname (if any) _____

Ages of sisters _____ Ages of brothers _____

Name(s) of any family member in treatment now or previously in this office:

Father's name _____ Work telephone _____ ext. _____

Address if different than patient _____

Place of employment _____ Cell/Pager # _____

Mother's name _____ Work telephone _____ ext. _____

Address if different than patient _____

Place of employment _____ Cell/Pager # _____

Person to contact for appointments _____ Telephone _____

Parent marital status: Married Divorced _____

Financial Responsibility: Both Parents Father Mother

Patient's Dentist _____ Family Dentist _____

Patient's Physician _____ Previous Orthodontist _____

Who referred you? _____

Insurance Company _____ Policy Number _____

Insured Full Name _____ DOB _____ Sex _____

MEDICAL QUESTIONNAIRE

Height _____ Weight _____ Sex _____ General Health _____

Tonsils: In ___ Out ___ Adenoids: In ___ Out ___ Frequency of colds _____

Habits: (example, tongue thrust, nail biting, thumb sucking, clenching or grinding of teeth, etc.)

Food or drug allergies _____

Does patient require premedication for medical or dental procedures? _____

Has patient reached puberty? _____ Approximate age occurred _____

Date of last dental cleaning _____ Frequency of visits _____

Have x-rays been taken in the last 6 months? _____

Any relative with an orthodontic problem similar to yours? _____

Any clicking or pain in "jaw joint" area? _____ (If the answer is "yes", please answer the questionnaire at the end of this form and fill out facial diagram questionnaire).

If you have any questions, please ask for assistance.

Are you positive, negative, or indifferent to orthodontic treatment? _____

Additional information that may be beneficial in evaluating your need for orthodontic treatment:

Please list your hobbies or interests: _____

HEALTH HISTORY

REVIEW OF SYSTEMS

Please do not write in spaces below

CARDIOVASCULAR			
	yes	no	
1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told you have heart trouble?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told you have high or low blood pressure?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Do you get out of breath easily?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had rheumatic fever?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a heart murmur as a consequence of rheumatic fever or prolapsed mitral valve (<u>underline which</u>)?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told that you have a heart murmur of any cause?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a heart attack?
8.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have spells of dizziness, fainting or black outs?
9.	<input type="checkbox"/>	<input type="checkbox"/>	Do your ankles become easily swollen?
10.	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from angina pectoris (chest and left arm pain)?

SPECIAL SENSES			
	yes	no	
1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had earaches or other ear related problems?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had eye problems (other than corrective lenses) or have you had eye surgery?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any change in your sense of taste or smell?

RESPIRATORY			
	yes	no	
1.	<input type="checkbox"/>	<input type="checkbox"/>	Is your nose often stuffed-up?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have the flu or a cold more than twice a year?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma, hayfever, sinusitis, or frequent sore throats?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had pneumonia?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had tuberculosis?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a fungus infection of the lung?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a chronic cough?
8.	<input type="checkbox"/>	<input type="checkbox"/>	Do you ever cough up blood?
9.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have bronchitis or emphysema?

NEUROLOGIC			
	yes	no	
1.	<input type="checkbox"/>	<input type="checkbox"/>	Has a physician told you you have neuritis, neuralgia or neurosis?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have numbness or tingling feelings anywhere?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a nervous breakdown?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Are you anxious frequently?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel depressed?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Have you been told you have epilepsy or seizures?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have Parkinson's disease?

ENDOCRINE			
	yes	no	
1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you or any member of your family had diabetes?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have thyroid problems or take thyroid tablets?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other gland problems?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Are you thirsty frequently?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Do you urinate frequently, especially at night?

GASTROINTESTINAL			
	yes	no	
1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had jaundice, liver trouble or hepatitis?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have stomach or peptic ulcers?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent or prolonged diarrhea?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Are you constipated more than 3 days in a row?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Have you gained or lost much weight recently?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Do you regurgitate blood?

GENITOURINARY		
	yes	no
1.	<input type="checkbox"/>	<input type="checkbox"/> Have you ever been told that you have kidney or bladder trouble?
2.	<input type="checkbox"/>	<input type="checkbox"/> Have you had any venereal diseases (syphilis, gonorrhea, genital herpes, AIDS)?
3.	<input type="checkbox"/>	<input type="checkbox"/> Have you had any reproductive tract problems?

HEMATOLOGIC		
	yes	no
1.	<input type="checkbox"/>	<input type="checkbox"/> Have you had anemia?
2.	<input type="checkbox"/>	<input type="checkbox"/> Do you have leukemia?
3.	<input type="checkbox"/>	<input type="checkbox"/> Have you ever had excessive bleeding following tooth removal or cuts, or have you had frequent nose bleeds?

IMMUNOLOGIC		
	yes	no
1.	<input type="checkbox"/>	<input type="checkbox"/> Are you sensitive or allergic to any medicines? (penicillin, sulfa drugs, aspirin, etc.)
2.	<input type="checkbox"/>	<input type="checkbox"/> Are you allergic to any foods, metals, pollens?
3.	<input type="checkbox"/>	<input type="checkbox"/> Have you been treated for a skin disease?
4.	<input type="checkbox"/>	<input type="checkbox"/> Do you have a defective immune system?

MUSCULOSKELETAL		
	yes	no
1.	<input type="checkbox"/>	<input type="checkbox"/> Are your joints often painfully swollen or do you have arthritis?
2.	<input type="checkbox"/>	<input type="checkbox"/> Do you have back problems?
3.	<input type="checkbox"/>	<input type="checkbox"/> Have you had more than one fracture or dislocation?

SURGERY - ANESTHESIA		
	yes	no
1.	<input type="checkbox"/>	<input type="checkbox"/> Have you had an operation?
2.	<input type="checkbox"/>	<input type="checkbox"/> Have you had a series of shots or injections?
3.	<input type="checkbox"/>	<input type="checkbox"/> Have you ever had anesthesia? ____ Local ____ General
4.	<input type="checkbox"/>	<input type="checkbox"/> Have you ever been told not to take novocaine or any other medication?
5.	<input type="checkbox"/>	<input type="checkbox"/> Have you ever been told you have cancer or a tumor?
6.	<input type="checkbox"/>	<input type="checkbox"/> Have you ever had chemotherapy or radiation therapy? (Underline which)
7.	<input type="checkbox"/>	<input type="checkbox"/> Have you ever had an organ or bone marrow transplant?

WOMEN		
	yes	no
1.	<input type="checkbox"/>	<input type="checkbox"/> Are you pregnant? Expected delivery date _____

FACIAL PAIN HISTORY		
	yes	no
1.	<input type="checkbox"/>	<input type="checkbox"/> Have you ever had severe pains of the face or head?
2.	<input type="checkbox"/>	<input type="checkbox"/> Do you suffer from headache, eye pain or migraine?
3.	<input type="checkbox"/>	<input type="checkbox"/> Do you have ear pain or pain in front of your ears?
4.	<input type="checkbox"/>	<input type="checkbox"/> Does it hurt when you chew?
5.	<input type="checkbox"/>	<input type="checkbox"/> Does your jaw make noise that bothers you or others?
6.	<input type="checkbox"/>	<input type="checkbox"/> Does the pain or discomfort interfere with your work or other activities?

I verify that, to the best of my knowledge, the above health history is correct.

Overall health _____	Any additional information? _____
_____	_____
_____	_____
When was patient's last physical exam by a Physician _____	Physician's Name _____
_____	Address _____
_____	Phone () _____

MEDICATIONS (List all medications taken in the past 6 months)	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HOSPITALIZATIONS			
Year	City	Reason	Complications

Patient /Parent Signature

Date

ADAPTED FROM FORMS UTILIZED BY
THE DEPARTMENT OF ORTHODONTICS
UNIVERSITY OF FLORIDA