* MEDICAL QUESTIONNAIRE *

GENERAL PATIENT INFORMATION

Date: ____________ Date of Birth: ___________ Age: _____ Sex: ❑ Male ❑ Female

First Name: _____________ Last Name: _________________ Nickname: ______________

Address: ____

City: ____________________________________ State: _____________ Zip: ___________

Home Phone: (___) _________________________ Cell: (___) __________________________

Father's Work: (___) ____________________ Mother's Work: (___) ____________________

Family Dentist: _________________ City: ___________________ Phone: _______________

How did you hear about our office? ____

Hobbies and interests: ____

School presently attending: ____

FAMILY INFORMATION

Parents: ***(check one)*** ❑ Married ❑ Divorced ❑ Separated ❑ Single

Name/ages of brothers & sisters: ____

Other family members with similar orthodontic condition: ________________________

Have we treated any of your family members? ______________________________________

Father's Name: ______________________________ Occupation: ____________________

Employer's Name & Address: ____

SSN: _______-______-_______ Birthdate: _____________________________________

Dental Insurance:___________________________ Phone Number: __________________

Mother's Name:______________________________ Occupation:_____________________

Employer's Name & Address: ____

SSN: _______-______-_______ Date of Birth: ________________________________

Dental Insurance:___________________________ Phone Number: __________________

(Please fill out next page)

NELSON HERSH, DDS, MS • MARSHA BEATTIE, DDS, MS
2300 HAGGERTY ROAD • SUITE 1160 • WEST BLOOMFIELD, MI 48323 • (248) 926-4100
5133 Highland Road, Waterford, MI 48327 • (248) 673-4100

MEDICAL HISTORY

General Health: ❑ Good ❑ Fair ❑ Poor Height: ________ Weight: ________

Please check Yes or No and what year:

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
Allergies	❑	❑	______	Epilepsy	❑	❑	______	H.I.V.	❑	❑	______
Emotional	❑	❑	______	Heart Murmur	❑	❑	______	Endocrine	❑	❑	______
Hepatitis	❑	❑	______	A.D.D.	❑	❑	______	Fainting	❑	❑	______
Hospitalized	❑	❑	______	Bone Disorder	❑	❑	______	Tonsils Removed	❑	❑	______
Asthma	❑	❑	______	Rheumatic Fever	❑	❑	______	Speech Difficulty	❑	❑	______
Bleeding Disorder	❑	❑	______								

Please give us any additional medical information or details: ______________________

____

Presently under medical attention for: ______________________

Do you require antibiotic pre medication prior to dental work? ______________________

If yes, which antibiotics do you take? ______________________

Have you grown much in the last year? ______________________

DENTAL HISTORY

Date of last dental check up: ______________________

Any history of trauma to teeth/face? ______________________

Any oral habits? ______________________

Does the patient play a musical instrument? ______________________

Breathing: ❑ Nose ❑ Mouth ❑ Snoring ❑ Difficulty at night?

Have you ever had or ever been treated for TMJ? ______________________

Please explain any dental problems: ______________________

Major reason for seeking an orthodontic consultation: ______________________

How did you first become aware of the orthodontic problem? ______________________

Is this your first orthodontic exam? ______________________

Questionnaire completed by: ______________________