Peter M. Greco, D.M.D.
Alexandra K. Greco, D.D.S.

Health Questionnaire

If the form is being completed by a parent or guardian, all questions pertain to the patient, not the parent or guardian.

Date: ____________________

Name: ____________________

Parent or Guardian's Name (if patient is a minor):

____

Address: ____________________

____

City/State/Zip: ____________________

Social Security #: ____________________

Date of Birth: ____________________

Home Phone: ____________________

Cell Phone: ____________________

Patient's Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children: __________

Section A

Occupation/School: ____________________

Grade: ____________________

Medical Doctor's Name and Address:

____

____

____

Date of Last Medical Visit: ____________________

Dentist's Name and Address: ____________________

____

Dentist's Phone #: ____________________

Date of Last Dental Visit: ____________________

Date of Last Dental X-rays: ____________________

Major Reason for Seeking Orthodontic Treatment:

____

____

____

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In the following sections, please answer all questions by circling “N” (for no) or “Y” (for yes), and fill in all the blank spaces where indicated.

Section B

1. N Y Has there been any change in your general health within the past year?
2. N Y Are you presently under the care of a physician?

   If yes, what is the condition being treated?

   ____

   ____

   ____

3. N Y Have you been hospitalized or suffered a serious illness during the past 3 years?

   If yes, what was the problem?

   ____

   ____

   ____

Section C Medical History

Have you ever had:

1. N Y Rheumatic fever or rheumatic heart disease?
2. N Y Heart murmur or congenital heart disease?
3. N Y Heart trouble, heart attack, stroke, pacemaker, or prosthetic (artificial) heart valve?
4. N Y Have you ever been advised to take antibiotics or other medicine prior to dental appointments?
5. N Y Shortness of breath or chest pain after mild exercise?
6. N Y Shortness of breath when you lie down?
7. N Y Do you snore excessively and/or are you constantly tired?
8. N Y High blood pressure?
9. N Y Do your ankles swell?
10. N Y Asthma, emphysema, or difficulty in breathing?
11. N Y Seizures or convulsions?
12. N Y Diabetes?
13. N Y A loss or gain of 10 pounds or more in the last year?
14. N Y Frequent urination (pass water more than 6 times a day)?
15. N Y Excessive thirst?
16. N Y Hepatitis, jaundice, or liver disease?
17. N Y AIDS, ARC, COVID-19, or positive antibody test to HTLV-III?
18. N Y Arthritis?
19. N Y Cancer/Chemotherapy?
20. N Y Stomach ulcers?
21. N Y Tuberculosis?
22. N Y Kidney trouble or renal dialysis?
23. N Y A persistent cough or coughing up blood?
24. N Y Venereal disease, gonorrhea, syphilis (bad blood)?
25. N Y Psychiatric therapy?
26. N Y Thyroid disease?
27. N Y Have you had surgery or radiation (X-ray) treatment for a tumor, growth, cancer, or other condition of the head, neck, or mouth?
28. N Y Do you bleed excessively when cut?
29. N Y Have you ever required a blood transfusion?
30. N Y Have you ever been diagnosed with any form of anemia?
31. N Y Have you ever been denied permission to donate blood?
32. N Y Do you have any hearing or vision problems (e.g. glaucoma), or other disabilities which we should consider in planning your dental treatment?
33. N Y Have you ever been in contact with any individual having hepatitis, tuberculosis, or AIDS?
34. N Y Are you addicted to or recovering from addiction to drugs or alcohol?
35. N Y Do you suffer from/or have you ever been treated for ear ringing, ear stuffiness, or jaw joint pain?
36. N Y Have you ever had any type of joint surgery, including joint replacement?
37. N Y if patient is a child, has he/she reached puberty?

Section D Allergy History

Are you allergic or have you ever had a reaction such as itching, rash, swelling of hands, feet or eyes, to:

1. N Y Novocaine or dental anesthetic?
2. N Y Penicillin?
3. N Y Other antibiotics? If yes, which?

____

____

____

4. N Y Aspirin?
5. N Y Codeine or other narcotics?
6. N Y Latex or rubber products?
7. N Y Other allergies:

____

____

____

Section E Medication Use

Have you taken any of the following drugs in the past 3 months?

1. N Y Anticoagulants or blood thinners?
2. N Y Medicine for high blood pressure or water pills?
3. N Y Cortisone (steroids)?
4. N Y Valium, Librium, or tranquilizers?
5. N Y Aspirin?
6. N Y Insulin or pills for diabetes?
7. N Y Digitalis or drugs for heart trouble?
8. N Y Nitroglycerin or other medication for angina pectoris (chest pain)?
9. N Y Birth control pills?
10. N Y Dilantin?
11. N Y Medicine not prescribed by an M.D. (i.e. "over-the-counter" medications)?
12. N Y Other medications:

____

____

Section F Women Only—otherwise proceed to Section G

1. N Y Are you pregnant or anticipating pregnancy in the near future?
2. N Y Are you presently taking birth control pills or hormones?

Section G Oral Health

1. What is your usual reason for visiting a dentist?
   - ☐ Routine checkup and cleaning
   - ☐ Only when I have a dental problem
2. N Y Have you received previous orthodontic consultation?
3. N Y Have you previously had orthodontic treatment?
   If yes, please specify:

   ____

   ____
4. N Y Have you been dissatisfied with your previous dental and/or orthodontic care?
   If yes, please comment:

   ____

   ____
5. N Y Do you have a history of fever blisters or "cold sores"?
6. N Y Do you have recurrent canker sores, mouth ulcers, or oral herpes infections?
7. N Y Do you bleed excessively after extractions, surgery, or wounds?
8. N Y Do you have dry mouth frequently?
9. N Y Do you have any disease, condition, or problem not listed?
   If yes, please specify:

   ____

   ____
10. N Y Are you aware of any oral habits such as finger or lip sucking, grinding, nail biting, or chewing on foreign objects such as pencils?
    Please specify any known habits:

    ____

    ____
11. N Y Were you ever told you have gum disease?
12. N Y Have your teeth or jaws ever been injured?
    If yes, how?

    ____

    ____

    When? ________________________________

Section H Social History

1. N Y Do you smoke?

   What?____________________

   How many per day?____________________

   How many years?____________________

2. N Y Do you drink alcoholic beverages?

   What?____________________

   How many per day?____________________

   ____

   How many years?____________________

Section I Family History

1. N Y Do you have a family history of diabetes, arthritis, or bleeding?
2. N Y If patient is a child, is he/she adopted?
3. N Y Does anyone in your family have a facial condition similar to yours?

   If yes, please describe:

   ____

   ____
4. N Y Do you have a family history of permanent teeth failing to form or erupt?
5. N Y Do you have a family history of periodontal (gum) disease?

Section J Insurance Information

Insured's name: ____________________

Insurance company: ____________________

Insured's employer:____________________

Insured's Social Security #: ____________________

Group#:__________ ID#:__________

Insured's Date of Birth:____________________

If you have dual insurance coverage:

Insured's name: ____________________

Insurance company: ____________________

Insured's employer:____________________

Insured's Social Security #: ____________________

Group#:__________ ID#:__________

Insured's Date of Birth:____________________

Health questionnaire completed by:

____

(Parent or guardian if patient is a minor)

Date completed:____________________

Signature: ____________________

Thank you for completing this questionnaire.