

Albert L. Kelling, D.D.S.
Orthodontics Care for Youth and Adults

Adult Health Questionnaire

Patient Name: _____ Goes By: _____ Age: _____

Your primary orthodontic concern: _____

Physician's name: _____ currently treating for: _____

Are there any medical conditions or allergies we need to be aware of at *each* visit? N Y _____

Drugs currently taking: _____

Taking medication for osteoporosis? N Y _____ Any Allergies? N Y _____

History of injury to face: _____

History of injury to teeth: _____

Symptoms related to jaw joint and chewing muscle function:

Facial achiness: N Y (circle)

Jaw joint achiness right: N Y

Jaw joint achiness left: N Y

Jaw joint sounds right: N Y

Jaw joint sounds left: N Y

Bruxism (Grinds teeth): N Y

Difficulty moving jaw: Occasionally Frequently

Clenching: Suspected Infrequent Frequent None

Headaches: None Infrequent, not of concern Frequent, of concern Migraine Right or Left

The above symptoms are: Rare Infrequent Mornings Sometimes during the day Daily

While Eating with consistent sounds (popping)

There is a history of: Degenerative joint disease Rheumatoid Arthritis Jaw joint dislocation Right or Left

Jaw joint trauma Right or Left

There is jaw joint/chewing muscle pain: On opening: Right Left On chewing: Right Left

While speaking: Right Left While sleeping: Right Left

Overall the pain is: Mild Moderate Severe

Patient has history of:

Heart disease N Y (circle) Diabetes N Y

Rheumatic fever N Y Bone disorder N Y

Kidney disease N Y Liver disease N Y

Congenital malformation N Y Psychiatric care N Y

Blood disorder/Prolonged bleeding N Y Muscle soreness or stiffness N Y

Hormone problems N Y Chronic fatigue N Y

Immunity disorder N Y Back problems N Y

Nervous disorder N Y Feeling depressed N Y

Excess stress at work N Y Anxiety N Y

Excess stress at home N Y Irritability N Y

Ever been in an accident involving your head, back or neck? _____

Hospitalized in the past 3 years? _____

Received blood transfusions or blood injections in the last 3 months? _____

Any acute respiratory disease or trouble breathing now, night sweats, unexplained fever, weight loss, lumps in neck, armpit or groin, discolored area of skin or mouth, persistent cough or persistent diarrhea? _____

Are you a member of a high-risk group for AIDS? _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature _____ Date: _____

Updates (date and initial) _____

** Please bring this health questionnaire to your visit. Thank you. **