

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

Youth Health Questionnaire

Patient Name: _____ Goes By: _____ Age: _____

Your primary orthodontic concern: _____

Patient's attitude toward orthodontics: Enthusiastic Indifferent Not Interested

Allergies affecting nasal breathing: No Suspected Mild Moderate Severe

Physician's name: _____ currently treating for: _____

Any medical conditions or allergies we need to be aware of at each visit? N Y _____

Drugs currently taking: _____

Allergic to: _____

Tonsils: Possibly enlarged Enlarged Removed (date) _____

Adenoids: Possibly enlarged Enlarged Removed (date) _____

History of injury to face: _____

History of injury to teeth: _____

Degree of cooperation with orthodontic treatment you expect: High Average Low

Recurrent: Tonsillar Problems Stuffy Nose Ear Infections Headaches

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

Blood disorder/Prolonged bleeding N Y

Psychiatric care N Y

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

Signature (Parent's signature if minor) _____ Date _____

Updates (date and initial) _____

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