Jarosz & Valente Orthodontics, P.C.
Practice Limited to Orthodontics
Children & Adults
www.jvortho.com

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WELCOME TO OUR OFFICE!

PLEASE FILL IN THE FOLLOWING:

Patient's Name_________________________ (First / Middle / Last) Age ________ Date ________

Home Address_______________ Grade ________ Birthdate ________ (Mo. / Date / Yr.) Sex (____) (____) (M / F)

City_______________ Zip ________ Home Phone ________________

Married ☐ Single ☐ Name of spouse or closest relative ________________ Relationship ________

IF MINOR:

Father's Name (if applicable) ________________________

Employed by ________________ Occupation ________

Business Address________________ Bus. Phone ________

City________________ State ________ Zip ________

Mother's Name (if applicable)________________________

Employed by ________________ Occupation ________

Business Address________________ Bus. Phone ________

City________________ State ________ Zip ________

Person responsible for this account________________ Relationship________

Address (if different from above)________________________

City________________ State ________ Zip ________

List siblings in the family Name________________ Age ________

Name________________ Age ________

Name________________ Age ________

Name________________ Age ________

Has patient or immediate family member had orthodontic treatment? Yes No

If so, please give name of Orthodontist ________________________

Whom may we thank for referring you to this office?________________________

Family Dentist________________________

Address________________________

City________________ State ________ Zip ________

Patient's special interests: ________________________

MEDICAL HISTORY

For the following questions, *circle yes or no,* whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Is patient in good health? .... Yes No

2. Has there been any change in patient's general health within the past year? .... Yes No

3. Is patient under the care of a physician? .... Yes No

If so, what is the condition being treated? ______________________

4. Height ______________________ Weight ______________________

5. Patient's last physical examination was on ______________________

6. The name and address of patient's physician(s) is ______________________

____

____

7. Has patient had any serious illness, operation, or been hospitalized? .... Yes No

If so, what was the illness or problem? ______________________

8. Is the patient taking any medicine(s) including birth-control and non-prescription medicine? .... Yes No

If so, what medicine(s) are you taking: ______________________

9. Does patient have or have they had any of the following diseases or problems?

a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease .... Yes No

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) .... Yes No

1) Does patient have chest pain upon exertion? .... Yes No

2) Is patient ever short of breath after mild exercise or when lying down? .... Yes No

3) Do patient's ankles swell? .... Yes No

4) Does patient have inborn heart defects? .... Yes No

5) Does patient have a cardiac pacemaker? .... Yes No

c. Allergy .... Yes No

d. Sinus trouble .... Yes No

e. Asthma or hay fever difficulty in breathing through nose (mouth breathing) .... Yes No

f. Fainting spells or seizures .... Yes No

g. Persistent diarrhea or recent weight loss .... Yes No

h. Diabetes .... Yes No

i. Hepatitis, jaundice or liver disease .... Yes No

j. AIDS or HIV infection .... Yes No

k. Thyroid problems or other glandular problems .... Yes No

l. Respiratory problems, emphysema, bronchitis, etc. .... Yes No

m. Arthritis or painful swollen joints .... Yes No

n. Stomach ulcer, hyperacidity repeated upset stomach .... Yes No

o. Kidney trouble .... Yes No

p. Tuberculosis .... Yes No

q. Persistent cough or cough that produces blood .... Yes No

r. Persistent swollen glands in neck .... Yes No

s. Low blood pressure .... Yes No

t. Sexually transmitted disease .... Yes No

u. Epilepsy or other neurological disease .... Yes No

v. Problems with mental health .... Yes No

w. Cancer .... Yes No

x. Problems of the immune system .... Yes No

y. Repeated colds .... Yes No

aa. Tonsils and adenoids removed .... Yes No

bb. Ear disorders, psoriasis, gout, migraine headache .... Yes No

cc. Osteoporosis or any other bone related conditions .... Yes No

10. Has the patient had abnormal bleeding? .... Yes No

a. Has the patient ever required a blood transfusion? .... Yes No

11. Does the patient have any blood disorder such as anemia? .... Yes No

12. Has patient ever had any treatment for a tumor or growth? .... Yes No

13. Is patient allergic or has he/she had a reaction to:

a. Local anesthetics .... Yes No

b. Penicillin or other antibiotics .... Yes No

c. Sulfa drugs .... Yes No

d. Barbiturates, sedatives, or sleeping pills .... Yes No

e. Aspirin .... Yes No

f. Iodine .... Yes No

g. Codeine or other narcotics .... Yes No

h. Jewelry .... Yes No

i. Other________________

14. Has patient had any serious trouble with any previous dental treatment? .... Yes No

If so, explain________________

____

15. Does patient have any disease, condition, or problem not listed above that you think I should know about? .... Yes No

If so, explain________________

____

IF MINOR:

16. Has the patient:

a. Had difficulty in school? .... Yes No

If so, explain________________

b. Had a history of hyperactivity or a learning disability? .... Yes No

d. Had a history of any behavior disorder? .... Yes No

e. Had any professional counseling? .... Yes No

17. Is the patient:

a. A very sensitive individual? .... Yes No

b. Very concerned with his or her orthodontic problem? .... Yes No

18. Does the patient:

a. Suck thumb or finger? .... Yes No

b. Play a musical instrument? .... Yes No

If so, what instrument________________

c. Had a history of sleeping or eating disorders? .... Yes No

d. Bite nails or lips? .... Yes No

e. Have any difficulty with speech? .... Yes No

f. Have any tongue habits? .... Yes No

g. Wear any removable dental appliances? .... Yes No

WOMEN

19. Is patient pregnant? .... Yes No

DENTAL HISTORY

1. Does patient clench or grind his/her teeth during the day? .... Yes No
2. Has patient been made aware he/she clenches or grinds teeth during the night? .... Yes No
3. Does patient ever wake up with an awareness of, or about, teeth or jaw like he/she has had them clenched in sleep? .... Yes No
4. Does patient get headaches? .... Yes No
5. Does patient have chronic neck and shoulder pains? .... Yes No
6. Does patient now have, or ever had, a repetitively tight or stiff neck? .... Yes No
7. Does patient now have, or ever had, pain in his/her jaw joint (in and about the ears)? .... Yes No
8. Does patient now have, or ever had, pain in the sides of his/her face, head and neck? .... Yes No
9. Does patient now have, or ever had, a binding or clicking jaw joint? .... Yes No
10. Does patient have other joints that click? .... Yes No
11. Has patient suffered any dislocated joints? .... Yes No
12. Has patient ever experienced an inability to move his/her jaw or open mouth widely? .... Yes No
13. Do any family members have jaw joint problems (clicking, pain, locking, etc.)? .... Yes No

    If so, explain ______________________________

14. Has the patient ever injured his/her face, jaw, head or neck (i.e., sports injury, auto accident or fall)? .... Yes No

    If so, explain ______________________________

15. Has the patient had any previous orthodontic treatment? .... Yes No

    If so, explain ______________________________

Reason for consultation appointment ______________________________

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I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Jarosz & Valente Orthodontics, P.C., or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____
Signature of Patient or Responsible Party - Relationship

For completion by the orthodontist.

Comments on patient interview concerning patient history: ______________________________

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______________________________ (Date)

______________________________ (Signature)