



Date: \_\_\_/\_\_\_/\_\_\_

# YOUTH HEALTH QUESTIONNAIRE

(Please Complete All Four Pages)

## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Preferred Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Patient's School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Name & Age of Siblings: \_\_\_\_\_  
 Please list patient's hobbies and interests: \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_  
 Why are you seeking an orthodontic evaluation? \_\_\_\_\_  
 Has anyone in the family been treated in this office before? \_\_\_\_\_

## Parent/Guardian Information

Parent Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Business Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Parent Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Business Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Emergency Contact

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_



Date: \_\_/\_\_/\_\_

Patient Name: \_\_\_\_\_

### Medical History

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of last physical exam: \_\_/\_\_/\_\_ Patient's Height/Weight: \_\_\_\_/\_\_\_\_

Please describe your present health:  Excellent  Good  Fair  Poor

Has your health changed in the last year?  Yes  No

If yes, please explain \_\_\_\_\_

Are you presently under the care of a physician?  Yes  No

If yes, please explain \_\_\_\_\_

Are you presently taking any form of medication?  Yes  No

If yes, please list \_\_\_\_\_

Do you smoke or use tobacco products?  Yes  No

Have you ever had an allergic reaction to any medication?  Yes  No

If yes, please list \_\_\_\_\_

Have you ever had an allergic reaction to any food or other substance?  Yes  No

If yes, please list \_\_\_\_\_

Have you ever been hospitalized?  Yes  No

If yes, please explain \_\_\_\_\_

Have you begun menstruation? (If applicable)  Yes  No

If yes, at what age? (If applicable) \_\_\_\_\_

Do you wear contact lenses?  Yes  No

*Do you have or have you ever had any of the following:*

Asthma  Yes  No Stomach Ulcers  Yes  No

Anemia  Yes  No Fainting Episodes  Yes  No

Abnormal Bleeding  Yes  No Seizures or Epilepsy  Yes  No

High Blood Pressure  Yes  No Migraine Headaches  Yes  No

Diabetes  Yes  No Tuberculosis  Yes  No

Hepatitis, Liver Problems  Yes  No Venereal Disease (Herpes)  Yes  No

Kidney Problems  Yes  No HIV Infection  Yes  No

Cancer  Yes  No AIDS or Other Immune

Thyroid Problems  Yes  No System Disorder  Yes  No

Ear Problems/Hearing Loss  Yes  No Arthritis/Joint Disorders  Yes  No

Hives/Skin Rash  Yes  No

Rheumatic Fever or Rheumatic Heart Disease  Yes  No

Damaged Heart Valves (Mitral Valve Prolapse, Artificial Heart valve, Heart Murmur)  Yes  No

If yes, do you need to be *premedicated* for dental procedures?  Yes  No

Cardiovascular Disease (Heart Trouble, Heart Attack, Coronary Insufficiency,

Coronary Occlusion Arteriosclerosis, Stroke)  Yes  No

If your child has any disability (mental, physical, or emotional), please specify: \_\_\_\_\_

If your child identifies with a gender other than his/her birth gender, please specify: \_\_\_\_\_

(\*If you would like to discuss this in private with our staff, please do so.)



Date: \_\_/\_\_/\_\_

Patient Name: \_\_\_\_\_

### Dental History

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of last dental visit: \_\_/\_\_/\_\_

Have you previously consulted an orthodontist?  Yes  No

If yes, when? \_\_\_\_\_

Have you ever had any orthodontic treatment?  Yes  No

If yes, when? \_\_\_\_\_

Were you satisfied with the treatment result?  Yes  No

Were any extractions performed?  Yes  No

If yes, how long ago and for what reason? \_\_\_\_\_

Is there a family history of missing teeth?  Yes  No

If yes, please describe \_\_\_\_\_

Do your gums bleed when you brush your teeth?  Yes  No

Is any part of your mouth sensitive to pressure?  Yes  No

Is any part of your mouth sensitive to temperature?  Yes  No

Have you ever had a thumb/finger sucking habit?  Yes  No

If yes, has the habit stopped? \_\_\_\_\_ When? \_\_\_\_\_

Do you breathe predominantly through your mouth?  Yes  No

Have you had tonsils/adenoids removed?  Yes  No

Do you snore?  Yes  No

Do you have or are you being treated for sleep apnea?  Yes  No

Do you clench or grind your teeth during the day?  Yes  No

Have you been made aware of clenching or grinding your teeth during sleep?  Yes  No

Do you have, or have you ever had, pain in your jaw joint(s) or sides of your face?  Yes  No

Have you ever had any clicking or popping in your jaw joint(s)?  Yes  No

Have you ever had any difficulty opening your mouth?  Yes  No

Have you ever experienced pain when opening your mouth wide?  Yes  No

Have you ever had any injury to your jaw or face?  Yes  No

If yes, please describe \_\_\_\_\_

Have you ever had any injury to your teeth?  Yes  No

If yes, please describe \_\_\_\_\_

Do you have any relatives that have been treated with orthognathic/jaw surgery?  Yes  No

If yes, please describe \_\_\_\_\_

Are you involved in any contact sports that require a mouthguard?  Yes  No

If yes, please describe \_\_\_\_\_



Date: \_\_/\_\_/\_\_

Patient Name: \_\_\_\_\_

### Responsible Party Information

Individual Responsible for Account: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Marital Status: \_\_\_\_\_

### Dental Insurance Information (No Medical Insurance Info Needed)

Primary Insured's Name: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group No.: \_\_\_\_\_ Policy: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's Date of Birth: \_\_/\_\_/\_\_ Insured's Employer: \_\_\_\_\_

Orthodontic coverage\*: \$ \_\_\_\_\_  Lifetime Max  Annual

Do you have dual dental coverage?  Yes  No

If Yes:

Secondary Insured's Name: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group No.: \_\_\_\_\_ Policy: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's Date of Birth: \_\_/\_\_/\_\_ Insured's Employer: \_\_\_\_\_

Orthodontic coverage\*: \$ \_\_\_\_\_  Lifetime Max  Annual

\*To determine your policy's orthodontic coverage, terms, deductibles and claim payment policies, contact your insurance company before the exam and indicate the amount of coverage in the provided space.

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_