HEALTH QUESTIONNAIRE - *for the office of Dr. Albert J. Fontaine DMD*

Do you have or have you ever had:

____Heart Trouble
____Arthritis
____Rheumatic fever
____Heart murmur, mitral valve prolapse
____Heart Prosthesis
____Prolonged bleeding
____Thyroid disorders
____Tense personality
____Psychiatric treatment
____Frequent earaches or infections
____Visual or hearing impaired
____Drug allergies
____Hepatitis
____Liver disease
____Mononucleosis
____Previous transfusions
____Anything else not listed

____Jaundice
____Kidney desease
____Epilepsy
____Immune disorders (AIDS, etc.)
____Hives, rashes, hay fever
____High blood pressure
____Low blood pressure
____Diabetes (or family history)
____Tuberculosis
____Emphysema
____Asthma
____Shortness of breath or chest pains on mild exertion
____Stomach problems or ulcer
____Previous hospitalizations
____Anemia
____Currently taking medications. Please list:_____
_____

Do you have:

____Sensitive teeth
____Cracked, broken teeth
____Bleeding gums
____Swelling
____Pain on chewing
____Speech problems
____Frequent headaches

____Jaws get stuck or loaded
____Difficulty opening
____Jaw joint noises (clicks, pops, etc.)
____Bite feels uncomfortable
____Bite feels uncomfortable
____Ringing in the ears
____Muscular spasm

Please describe, in your own words, the orthodontic problem.

_____

Has the patient ever had orthodontic care?_____
Has anyone else iln the familiy received orthodontic care?_____
Could you please give the name and ages of any siblings to use for comparison._____
_____
How do you think you would react to wearing braces?_____
At what age did menarche (menstruation) begin?_____

Do you have any of the following habits:

____Lip biting or sucking
____Thumb or finger sucking
____Nail or pencil biting

____Tongue thrusting or lisp
____Teeth grinding or clenching
____Mouth breather

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND WILL INFORM THE OFFICE STAFF OF ANY CHANGES DURING MY TREATMENT. _____

Parent/Guardian Signature