



Perelmuter Orthodontics

916 Dupont Road
Louisville, KY 40207
897-1112

Today's Date _____

Health Questionnaire

Please Print

Patient's Name _____ Birthdate _____ Home Phone _____

Cell phone _____ E-Mail _____

Address _____ City _____ State _____ Zip Code _____

SSN _____ Employment _____

Business Phone _____ E-Mail Address _____

Spouse _____ Employment _____

Business Phone _____ SSN _____

If patient is a minor

Mother _____ SSN _____ cell phone _____

Employment _____ Business Phone _____

Father _____ SSN _____ cell phone _____

Employment _____ Business Phone _____

Parent's marital status: Married _____ Divorced _____ Single _____ Domestic Partners _____

Would you like reports sent to parent not living with child? Yes _____ No _____

If yes, that parent's name and address _____

- Are you in good health? _____
- Have there been any changes in your general health within the past year? _____
If so, please explain _____

- Are you now under the care of a physician? _____
If so, please explain _____

- Please list any medications you are taking and the reasons for taking them _____

- If you have been hospitalized, had a serious illness or operation, please explain the problems and approximate dates _____

- When was your last physical examination? _____
- Please list name(s) and address (s) of your physician(s) _____

PLEASE TURN PAGE OVER

Please check yes or no to the following conditions that apply

- Tetracycline Yes _____ No _____
- Mouth breathing.....Yes _____ No _____
- Sinus problems Yes _____ No _____
- Environmental allergies ,hay fever or Asthma Yes _____ No _____
- Allergies to latex, ibuprofen, Tylenol, metal Yes _____ No _____
- Emphysema.....Yes _____ No _____
- Hives or skin rash Yes _____ No _____
- Allergies to medications Yes _____ No _____
- High blood pressure.....Yes _____ No _____
- Low blood pressure Yes _____ No _____
- History of stroke Yes _____ No _____
- Anemia/blood disorder or excessive bleeding.....Yes _____ No _____
- Tobacco use Yes _____ No _____
- Heart disease/rheumatic fever
or heart murmur.....Yes _____ No _____
- Drug or alcohol dependency Yes _____ No _____
- Emotional or mental illness Yes _____ No _____
- Congenital heart condition.....Yes _____ No _____
- Shortness of breath Yes _____ No _____
- Pain in chest upon exertion.....Yes _____ No _____
- Cardiac or coronary disease/pacemaker Yes _____ No _____
- Arthritis or artificial jointsYes _____ No _____
- Diabetes Yes _____ No _____
- Epilepsy or seizures Yes _____ No _____
- Kidney problems.....Yes _____ No _____
- Restricted diet Yes _____ No _____
- Thyroid disorders Yes _____ No _____
- Tuberculosis.....Yes _____ No _____
- AIDS or HIV positive Yes _____ No _____
- Hepatitis or liver disorders Yes _____ No _____
- History of benign or malignant tumors/cancer.....Yes _____ No _____
- History of radiation treatments Yes _____ No _____
- Headaches, neckaches or back pain Yes _____ No _____
- Insomnia (difficulty sleeping) or sleep apnea.....Yes _____ No _____
- (women) pregnancy or nursing Yes _____ No _____
- Hearing loss, ear aches or ringing.....Yes _____ No _____
- Dizziness or fainting Yes _____ No _____
- Tonsils removed Yes _____ No _____
- Adenoids removed.....Yes _____ No _____
- Osteoperosis Yes _____ No _____
- Growth Hormone Yes _____ No _____
- Birth defects or heredity problems Yes _____ No _____
- Accidents or broken bones.....Yes _____ No _____
- History of herpes Yes _____ No _____
- Behavioral problems, ADD,ADHD or learning disabilities Yes _____ No _____

Please explain any conditions to which you answered yes: _____

Please make any addition which you feel would help us in evaluating your condition: _____

Date: _____

Signature _____