

DR. VOHN ROSANG
ORTHODONTIST
PATIENT HEALTH QUESTIONNAIRE

NAME: _____

BIRTHDATE: _____

Your overall health is an important consideration in providing your Orthodontic care. To help us ensure your well-being while undergoing treatment in our office, please answer the following questions. Some of your answers may directly affect the course of your treatment or they may alert us to the presence of a condition you are presently unaware of. All information will be considered confidential and for our records only.

If you are unsure of how to answer a particular question, the doctor will be happy to assist. Thank you.

(please circle)

- Yes No Are you in good health?
Yes No Are you currently undergoing medical treatment of any kind?
Describe _____ Name of Physician _____
Yes No Female patient: Are you pregnant? Due _____
Yes No Are you wearing a pacemaker?
Yes No Do your jaw joints click or hurt?
Yes No Have you ever had periodontal (gum) treatment?
Yes No Have you ever had root canal treatment?
Yes No Have you ever had Hepatitis A, B, or C?
Yes No Have you been told you have AIDS or a related problem?
Yes No Have you ever had a heart murmur, rheumatic fever, scarlet fever, or artificial heart valves?

Please check if you have or have had:

- | | |
|--|--|
| <input type="checkbox"/> asthma, chronic bronchitis | <input type="checkbox"/> epilepsy/convulsions |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> alcoholism or drug dependence |
| <input type="checkbox"/> allergies | <input type="checkbox"/> nervous disorders or psychiatric care |
| <input type="checkbox"/> heart attack, stroke or angina | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> kidney or bladder trouble |
| <input type="checkbox"/> anemia | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> cancer, radiation treatment or chemotherapy | <input type="checkbox"/> diabetes |
| | <input type="checkbox"/> tuberculosis |
| | <input type="checkbox"/> bleeding disorders |
| | <input type="checkbox"/> ulcers/colitis |

Please list any prescription medications you are taking

Please list any medications you are allergic to or have had a reaction to

Please sign _____ OR _____ DATE _____
Patient Parent or guardian if under 18

Dr. Rosang is often requested to instruct in orthodontics. Anonymous use of photographs and models for teaching and research purposes may be employed unless specifically requested otherwise.