H. Ivan Orup, Jr., DMD, MMSc, PC

Specialist in Orthodontics for Children & Adults

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978.369.3690 ▪ www.drorup.com

ADULT HEALTH QUESTIONNAIRE

(Please Complete All Four Pages)

Date: __/__/__

Patient Information

Last Name: ______________________ First Name: _____________________ MI: _____________
Preferred Name: __________________ Age: _____ Birthdate: ____________ Gender: __________
Home Address: ____
City: ______________________ State: _________ Zip: ___________ Home Phone:__________
Whom may we thank for referring you to our office? ____
Why are you seeking an orthodontic evaluation? ____
Has anyone in your family been treated in this office before? ____________________________
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: ______________________________

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

Member
American Association of
Orthodontists

Date: __/__/__ **Patient Name: ______________________________**

Medical History

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 ____

Is there a possibility that you might be pregnant? (If applicable) ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Have you been in contact with anyone at risk for the following (please check those that apply):

☐ Tuberculosis ☐ Hepatitis ☐ Herpes ☐ AIDS

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

Condition			Condition		
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	☐ 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

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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 ______________________________________

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Date: __/__/__ **Patient Name: ____________________________**

Responsible Party Information

Individual Responsible for Account: ____
Billing Address: ____
City: ____________________ State: ______ Zip: ___________________________________
Relationship to Patient: __________________

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 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: _________________________________

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