G. GIBSON MCCALL, III, DDS, MS, PLLC

Practice Limited to Orthodontics

1909 Turnbury Drive
Greenville, NC 27858
(252) 353-9000

Date: _____

Health History Questionnaire

Patient's Name _____ Sex: M ☐ F ☐

Address: _____ Birthdate: _____

_____

_____

_____ Phone: _____

Last/First Name of Person Completing This Form: _____

Relation to Patient: _____

Do you have insurance that covers the orthodontic treatment?

No ☐ Don't Know ☐ If **Yes** ☐ :

Subscriber's Name: _____ Subscriber's # _____

Name of Insurance Company: _____

Group: _____ Plan: _____

Please check in with the receptionist when you arrive for your appointment.
Please bring any Insurance forms or information you may have to your next appointment.

Thank you.

Instructions

1. Please complete the data requested above.
2. Please answer every question requested below, indicating a **NO** if not applicable.
3. If you answer **YES**, please check off any "specifics" of the problem and "Please Explain..." any specifics along with any medication and its dosage for the problem, if applicable.
4. Please sign and date the back page bottom, and bring this form with you to your appointment.

Medical History for (Name): _____

What is the name of your family Physician?_____ Date of your last visit to this physician _____

Are there any Medical Specialists you see regularly? _____ Speciality: _____

When was the last time you had a complete physical exam? Date: _____ Examining doctor's name: _____

What is your approximate height? ____ feet, ____ inches. What is your approximate weight? ____ pounds. Body Frame Size: Small ☐ Medium ☐ Large ☐

History of:		Specifics of Problems if *YES*:	*Please Explain ... Also indicate any Medication (& dosage)*
Head/Neck Problems?	NO☐ **YES**☐	Headaches: Migraine ☐ Sinus ☐ Eyes ☐ Temples ☐ Back of Head ☐ Painful Scalp ☐ Neck Pain ☐ Lumps in Neck ☐ Tired/Sore Neck Muscles ☐	
Neural Problems?	NO☐ **YES**☐	Epilepsy ☐ Seizures ☐ Numbness/Tingling ☐ Other ☐	
Eye Problems?	NO☐ **YES**☐	Pain ☐ Bloodshot ☐ Blurred Vision ☐ Pressure on Eyeballs ☐ Light Sensitivity ☐ Watery ☐ Drooping Eyelids ☐ _____	
Ear Problems?	NO☐ **YES**☐	Pain ☐ Clogged ☐ Hissing ☐ Ringing ☐ Dizziness ☐ Nausea ☐ Loss of Hearing Volume ☐ Loss of Balance ☐	
Nose/Sinus Problems?	NO☐ **YES**☐	Obstruction ☐ Stuffiness ☐ Runny Nose ☐ _____	
Throat Problems?	NO☐ **YES**☐	Sore Throat ☐ Swallowing Difficulties ☐ Lump in Throat ☐ Laryngitis ☐ Voice Fluctuations ☐ Tongue Pain ☐ Persistent Coughing/Clearing Throat ☐	
Breathing Problems?	NO☐ **YES**☐	Asthma ☐ Wheezing ☐ Shortness of Breath ☐ Chronic Cough ☐ Cough up Blood/Sputum ☐	
Back, Shoulders, Extremity Problems?	NO☐ **YES**☐	Aching Shoulders ☐ or Stiffness ☐ Lack of Mobility ☐ Upper ☐ Lower ☐ Back Pain ☐ Numbness in Arms ☐ Cramps in Legs: When Walking ☐ At Night ☐ Arms/Legs Weakness ☐ Leg/Ankle Swelling ☐ Gout ☐	
Bone Problems?	NO☐ **YES**☐	Break Easily ☐ Pain ☐ Arthritis ☐ Joint Pain ☐ Joint Swelling ☐	
Breast Problems?	NO☐ **YES**☐	Pain ☐ Lumps ☐ Disease ☐ _____ _____	
Heart Problems?	NO☐ **YES**☐	Coronary Heart Disease ☐ Heart Valve Disease ☐ High Blood Pressure ☐ Chest Pain ☐ Angina ☐ Heart Murmur ☐ Irregular Heartbeat ☐ Palpitations ☐	
Urinary System Problems?	NO☐ **YES**☐	Urgency ☐ Painful Urination ☐ Frequent Urination ☐ Nighttime Urination ☐ Release when Sneeze/Cough ☐ Blood in Urine ☐ Kidney Infection ☐	
Stomach & Intestine Problems?	NO☐ **YES**☐	Ulcers ☐ Bleeding ☐ Abdominal Pain ☐ Heartburn ☐ Nausea/Vomiting ☐ Constipation ☐ Diarrhea ☐ Gall Bladder Disease ☐ Intestinal Disease ☐ Black Stool ☐ Intolerance to: Milk ☐ Eggs ☐	
Endocrine Problems?	NO☐ **YES**☐	Pancreas ☐ Thyroid ☐ Pituitary ☐ HIV+ ☐ _____	

DR's. Initials _____

TC's. Initials _____

History of:		Specifics of Problems if *YES*:	*Please Explain ... Also indicate any Medication (& dosage)*
Liver Problems?	NO☐ **YES**☐		
Kidney Problems?	NO☐ **YES**☐		
Blood Problems?	NO☐ **YES**☐	Hemophilia ☐ Anemia ☐ Bruise Easily ☐ HIV+ ☐ Bleed Easily ☐ Blood Clots ☐ Had Stroke ☐	
Chronic Disease Problems?	NO☐ **YES**☐	Diabetes ☐ Cancer ☐ Hepatitis A ☐ B ☐ Tuberculosis ☐ Infectious Diseases ☐ Swelling ☐ Tonsilitis ☐ Excessive Colds ☐	
Skin Problems?	NO☐ **YES**☐	Eczema ☐ Dry ☐ Oily ☐ Itchy ☐	
One Time Problems?	NO☐ **YES**☐	Mumps (@ age _____) Rheumatic Fever (@ age _____) Measles (@ age _____) Chicken Pox (@ age _____)	
Heart Surgery?	NO☐ **YES**☐	Heart Valve (date _____) Pacemaker (date _____) Bypass (date _____) _____ (date _____)	
Other Surgery?	NO☐ **YES**☐	Tonsils (date _____) Adenoids (date _____)	
Serious Injury?	NO☐ **YES**☐	Broken Bones (date _____) _____	
Occupational Disease?	NO☐ **YES**☐ (ADULTS)		

Family History of:		If Yes, Which Family Members:	Comments on Family History of Diseases:
Diabetes?	NO☐ **YES**☐		
Cancer or Skin Cancer?	NO☐ **YES**☐		
Tuberculosis?	NO☐ **YES**☐		
Heart Disease?	NO☐ **YES**☐		
High Blood Pressure?	NO☐ **YES**☐		
Organ Disease?	NO☐ **YES**☐	Liver ☐ Kidney ☐ Lung ☐	
Kidney Disease?	NO☐ **YES**☐		
Lung Disease?	NO☐ **YES**☐		
Emotional Problems?	NO☐ **YES**☐		
Stroke?	NO☐ **YES**☐		
Arthritis?	NO☐ **YES**☐		

Habit Excesses?	NO☐ **YES**☐	Smoking (_____ Packs/Day) for _____ years Caffeine ☐ Alcohol ☐ Over Eating ☐	
Exercise Regularly?	NO☐ **YES**☐	_____ Hours/Day ☐ Week ☐ Month ☐	
Psychological Problems?	NO☐ **YES**☐	Anxiety ☐ Depression ☐ Psychiatric Disorder ☐ Insomnia ☐	
Presently Taking Medications?	NO☐ **YES**☐ (Dosage?)	Birth Control ☐ Diuretics ☐ Blood Pressure ☐ Blood Thinners ☐ Heart ☐ Tranquilizers ☐	
Allergic Reactions?	NO☐ **YES**☐	Hay Fever ☐ To Foods ☐ To Metals/Plastics ☐	
Drug Reactions?	NO☐ **YES**☐	Anti-Bacterial Drugs ☐	
Anesthetic Reaction?	NO☐ **YES**☐	Local Anesthetic ☐ General Anesthetic ☐	

Has the Patient Reached Puberty? Female started menstruation? NO☐ **YES**☐ Males had voice change? NO☐ **YES**☐

Has a physician indicated that the patient is **MATURING:** EARLIER than normal? NO☐ **YES**☐ NORMALLY? NO☐ **YES**☐
LATER than normal? NO☐ **YES**☐ _____

Which parent does the patient resemble? Mother ☐ Father ☐ Neither ☐ Both ☐

DR's. Initials _____
TC's. Initials _____

Dental History:

Name of your Family Dentist: _____ Date of your last visit to this dentist: _____

Dental Specialists who have treated you (Give names, Treatments & Dates): _____

How many times per day do you ***BRUSH*** your teeth? 0☐ 1☐ 2☐ 3+☐ How many times per day do you ***FLOSS*** your teeth? 0☐ 1☐ 2+☐

History of:			Specifics of Problems if *YES*:	Please Explain any *YES answers*:
Tooth Injury?	NO☐	**YES**☐	Chipped ☐ Broken ☐ Lost ☐	
Oral Disease?	NO☐	**YES**☐	Ulcers ☐ Sores ☐	
Jaw Joint Pain?	NO☐	**YES**☐	**Right T.M.J.** : Constant ☐ Periodic ☐ **Left T.M.J.**: Constant ☐ Periodic ☐ **Comments:**	When You: Chew ☐ Yawn ☐ Talk ☐ Open Wide ☐ When You: Chew ☐ Yawn ☐ Talk ☐ Open Wide ☐
Jaw Joint Noises?	NO☐	**YES**☐	**Right T.M.J.** : Clicking ☐ Popping ☐ Grating ☐ **Left T.M.J.**: Clicking ☐ Popping ☐ Grating ☐	At age:
Jaw Joint Locking?	NO☐	**YES**☐	**Right T.M.J.** : When Open ☐ When Closed ☐ **Left T.M.J.**: When Open ☐ When Closed ☐	Dates of Locking:
Grinding Your Teeth?	NO☐	**YES**☐	During The Day ☐ _____ When Sleeping ☐ _____	
Clenching Your Teeth?	NO☐	**YES**☐	During The Day ☐ _____ When Sleeping ☐ _____	
Bleeding Gums?	NO☐	**YES**☐	Usually ☐ Sometimes ☐ Rarely ☐ When: Brushing ☐ Flossing ☐ Eating ☐	Presently under a Dentist's care for it? Yes ☐ No ☐
Oral Habits?	NO☐	**YES**☐	Thumb Sucking ☐ Finger Sucking ☐ Tongue Thrusting ☐ Nail Biting ☐	
Other Oral Problems?	Speech Problems? NO☐ **YES**☐ NO☐	**YES**☐	Comments: _____ If YES, please explain: _____	

Have you ever had:

Teeth Extracted?	NO☐	**YES**☐	Which teeth? _____
Periodontal (gums) Treatment?	NO☐	**YES**☐	What kind of treatment? _____
Orthodontic (braces) Treatment?	NO☐	**YES**☐	What kind of treatment? _____
Endodontic (root canal) Treatment?	NO☐	**YES**☐	What kind of treatment? _____
Oral Surgery (jaw surgery) Treatment?	NO☐	**YES**☐	What kind of treatment? _____
Prosthodontic (crown & bridge) Treatment?	NO☐	**YES**☐	What kind of treatment? _____

I hereby certify that I have reviewed the above medical history and that it is accurate to my knowledge at this time. I will keep the doctor and staff of this practice informed of any changes in this information as it occurs.

_____ _____

Signature of Person Filling Out This Health History → **Date this history was completed**

_____

Signature of The T.C. who reviewed this health history

_____ _____

Signature that the examining ***DOCTOR*** reviewed this history **Date** of interview and ***DOCTOR*** review of this history

_____

Date above T.C. reviewed health history