Youth Patient Information and Health Survey

² atient's Name		Age	Birth date	Sex M	
Address					
-lome Phone		Cell Phone (ad	_Cell Phone (adult)		
mail (adult)		School		Grade	
Person responsible for finan	cial matters				
Name(s)					
City, State, Zipcode					
	Business Phone				
	Family Dentist	Family F	Family Physician		
Name					
Address					
City, State					
AMILY AND PATIENT INFORM	MATION				
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Present drugs or medications____

3345 S.W. Fairlawn Road

Topeka, KS 66614

785-267-3855

Orthodontics for Families

> Don C. Gordy, D.D.S. www.DrDonGordy.com

721 Wakarusa Dr., Suite 102 Lawrence, KS 66049 785-843-3183

RESPIRATORY HISTORY

Do you:

Have allergies to:	
Drugs:	
Food:	
Seasonal Grasses:	
Other:	
■ Breathe through mouth? Seldom□ Sometimes□ Usually□	
■ Snore when sleeping? No□ Yes□	
■ Have frequent colds? No□ Yes□	
■ Have frequent "Stuffy Nose?" No□ Yes□	
■ Have frequent sore throat or tonsillitis? No□ Yes□	
Have difficulty chewing or swallowing? No Yes	
Have you received medical treatment from an allergist or ear, nose, and throat specialist? No \square Yes \square	
If yes: When By Whom	
Nasal Surgery□ Tonsils removed□ Adenoids removed□	
DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY	
Has the patient had any unusual dental experiences? No \square Yes \square	
Specify	
Any injuries to the mouth, teeth or face? No \square Yes \square	
Specify	
Date of last dental checkupWere the patient's teeth cleaned? No Yes	
Has the patient had an orthodontic consult or treatment? No \square Yes \square	
Does the patient have Headaches? Neck Pain? Jaw Pain? Ear Pain? Face Pain? Eye Pain? Other?	3
Which side hurts? Right?□ Left?□ Both?□	
How long have you had these symptoms? If yes, please indicate when and where	
Years Days Months	
Is the pain constant?□ Aching?□ Shooting?□ Burning?□ Stabbing?□ Electrical?□ Other?□	
Worse in the afternoon? Worse in the morning? Does it hurt to chew? Does it hurt to open wide?	
Does the patient's jaw ever make a popping noise?□ Clicking?□ Grinding?□ Other?□	
Has the patient's jaw ever "locked" or slipped out of place? No□ Yes□	
Does the patient ever clench or grind his/her teeth? No \square Yes \square	
During the day? \Box During the night? \Box	
Does the patient have problems with his/her ears? Hearing? Dizziness? Other?	
Is it difficult to swallow? Painful?	
Are the teeth sore or sensitive? No Yes	
INDICATE HABITS, PAST OR PRESENT	
Thumb or Finger Sucking Tongue Thrust (reverse swallowing) Lip Biting Nail Biting	
Poor speech habits Other	
Additional comments	
Patient Signature	Date
Doctor Signature	Date

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