ORTODONTIS
ORTHODONTIST

BChD (Hons) (Pret), MChD (Ort)(Pret)

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GESONDHEIDSVRAELYS / HEALTH QUESTIONNAIRE

Pasient se Naam en Van / Patient's Name and Surname: ☐

Ouerdom / Age: ☐

Manlik / Male ☐ **Vroulik / Female** ☐

Ly u aan enige van die volgende toestande? / Have you ever had any of the following conditions?

J/Y	N		J/Y	N	
J/Y	N	Hartsiektes / Heart Disease	J/Y	N	Hooikoors / Hay fever
J/Y	N	Hepatitis B	J/Y	N	Bloedings neiging / Excessive bleeding
J/Y	N	Epilepsie / Epilepsy	J/Y	N	Rumatiekkoors / Rheumatic fever
J/Y	N	Gewrigsonsteking / Arhritis	J/Y	N	Longaandoenings / Lung problems
J/Y	N	Is u MIV Positief /Are you HIV Positive	J/Y	N	Mangels/Adenoide verwyder / Tonsils/Adenoids removed
J/Y	N	Diabetes	J/Y	N	Hormonale probleme / Hormonal problems
J/Y	N	Tuberkulose / Tuberculosis	J/Y	N	Geelsug of lewer probleme / Jaundice or liver problems
J/Y	N	Asma / Asthma	J/Y	N	Beensiekte /Bone disorder
J/Y	N	Endokriene afwykings / Endocrine disorders	J/Y	N	Allergië / Allergies
J/Y	N	ADHD / ADD	J/Y	N	Kanker / Cancer

J/Y N Temporomandibulêre gewrigs probleme / Temporomandibular joint condition

J/Y N Gebruik u tans of het u onlangs enige medikasie gebruik? / Do you currently or have you recently been using any medication?

Spesifiseer indien "Ja" aangedui / Specify if indicated "Yes": ______________________________

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Ouderdom waarop mangels/adenoiede verwyder is / Age when tonsils/ adenoids were removed

Jaar / Years ☐

Ouderdom waarop eerste melktand verskyn het / Age of eruption of first tooth

Jaar / Years ☐

J/Y N Het u enige gesigsnykunde ondergaan? / Have you had any facial surgery?
Indien wel, besonderhede / If so, details: ______________________________

J/Y N Enige beserings of trauma aan kake of tande? / Any injuries or trauma to jaws or teeth?
Indien wel, besonderhede / If so, details: ______________________________

J/Y	N	Het u enige spraak probleme? / Do you have any speech problems? Indien wel, besonderhede / If so, details: ________________
J/Y	N	Is u 'n mondasemhaler? / Are you a mouth breather?
J/Y	N	Het u u duim of vingers gesuig? / Did you suck a thumb or fingers? Indien wel,tot watter ouderdom / If so, till what age? ________________
J/Y	N	Het 'n tandarts al enige tande verwyder? / Were any teeth removed by a dentist?
J/Y	N	Is u bewus van enige afwesige of ekstra permanente tande? / Any missing teeth or extra permanent teeth?
J/Y	N	Het u al van tevore 'n ortodontis gekonsulteer? / Have you previously consulted an orthodontist?
J/Y	N	Is u gemotiveerd om ortodontiese behandeling te ondergaan? / Are you motivated to undergo orthodontic treatmer
J/Y	N	Enige familielid wat tans of vroeër ortodontiese behandeling ondergaan het? / Any family member that are currently or previously being treated orthodontically? Indien wel, besonderhede / If so, details: ________________
J/Y	N	Is u bewus van gewoontes soos tande klem of kners? / Are you aware of clenching or grinding of teeth?

Enige ander inligting van belang / Any further information relevant

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Ek verklaar dat ek die bogenoemde mediese geskiedenis deur gelees het, en dat dit volgens my meening akkuraat is. In die geval van toekomstige veranderinge, sal ek die praktyk dien ooreenkomstig verwittig .
I hereby certify that I have reviewed the above medical history and it is accurate to my knowledge. If there are any future changes in this information , I will inform this practice of these changes.

Datum / Date

Y	Y	Y	Y	M	M	D	D

________________ Handtekening van persoon wat die gesondheidsvraelys voltooi / Signature of person completing the health questionanaire

________________ Verwantskap / Relationship