

*Dr. Steven Cohen, DMD, MSD  
2517 South Broad Street  
Philadelphia, PA 19148  
215-271-8870  
www.phillybraces.com*

## Health Questionnaire

Patient's Name: \_\_\_\_\_ Date \_\_\_\_\_

Have you suffered any trauma or injuries to your teeth?      Yes      No  
Ex. Hit in the mouth by ball, accidents, falls

Are you allergic to any medication?      Yes      No  
If yes, please list: \_\_\_\_\_

Do you have any breathing difficulties or sinus problems?      Yes      No  
Ex. Asthma, Allergies, Hay Fever

Do you have any cardiovascular diseases?      Yes      No  
Ex. Heart trouble, high blood pressure, heart murmur

Do you have any artificial prosthesis?      Yes      No  
If yes, please specify: \_\_\_\_\_

Signature \_\_\_\_\_

If the patient is under the age of 18 years, then the parent or guardian must sign on the above line.