ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

NAME _________________________________________

I. SUBJECTIVE COMPLAINTS AND CONCERN

A. What are the patient’s or parents’ main concerns? Regarding the jaw and teeth?

Mild  Moderate  Severe

1. Facial Pain…………………
2. Gum Disease/Recession…..
3. Gum Problems ……………
4. Headaches ………………..
5. Jaw Joint Sounds………..
6. Jaw Pain………………..
7. Neck Pain…………………
8. Ringing or “Stuffy” Ears…

Bad Bite
“Buck” Teeth/Overjet
Crowding of upper Teeth
Crowding of lower Teeth
Crossbite
Dentist Recommended Seeing an Orthodontist
Gummy Smile
Impacted Tooth/Teeth
Improper Tooth position
Irregular Facial Proportions
Irregular Shaped Tooth/Teeth
Missing Tooth/Teeth
Mouth Too Small
Open Bite
Overbite
Prominent Lower Jaw (too ‘strong’)
Protrusion of Teeth
Recessive Lower Jaw (too ‘weak’)
Rotations
Small Teeth
Spaces
Thumb/Finger Habit
Underbite
Other _________________________________________

B. Family members with similar problems:

Father
Mother
Brother
Sister
Other ______________________________

II. MEDICAL DENTAL HISTORY

A. Present Health

<table>
<thead>
<tr>
<th>Condition</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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</thead>
<tbody>
<tr>
<td>Physical</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Emotional</td>
<td>☐</td>
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<tr>
<td>Under Stress</td>
<td>☐</td>
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B. Has the patient reached puberty

☐ Yes  ☐ No

C. Has the patient ever had any of the following conditions?

☐ Allergies
☐ Arteriosclerosis
☐ Asthma
☐ Autoimmune Disorder
☐ Blood Disease
☐ High Blood Pressure
☐ Lower Blood Pressure
☐ Bone Disorders
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Emotional Problems
☐ Endocrine Problems
☐ Epilepsy
☐ Female Problems
☐ Hearing Disorders
☐ Heart Disease
☐ Hepatitis
☐ HIV/AIDS/ARC (Circle)
☐ Kidney Disease
☐ Rheumatic Fever
☐ Ringing of Ears
☐ Sleep Disturbance
☐ Trauma (to face, teeth, jaws, or head)
☐ OTHER ______________________________

D. MEDICATIONS - Current medications taken by the patient:

☐ Antibiotics
☐ Birth Control Pills
☐ Bisphosphonates – (i.e. Fosamax, Boniva, etc…)
☐ Diet Pills (diuretics)
☐ Heart Pills (digitalis, etc.)
☐ Insulin
☐ Muscle Relaxants (valium, etc.)
☐ Pain Pills (Demerol, codeine, etc.)
☐ Sleeping Pills
☐ Tranquilizers (elavil, valium, etc.)
☐ Vitamins
☐ OTHER ______________________________

OVER ⇒
E. ALLERGIES TO MEDICATIONS/FOOD - The patient demonstrates an allergic response to:
- Antibiotics (specifically) _________________________
- Dairy Products
- Food Dyes
- Pain Pill (Specifically) ___________________________
- Wheat
- OTHER ______________________________________

F. OTHER PERTINENT INFORMATION - Has the patient ever had a history of the following?
1. Clicking in Jaw Joint …………………..☐
2. Difficulty Chewing …………………….☐
3. Difficulty in Swallowing ………………☐
4. Finger /Thumb Sucking …………………☐
5. Grinding Teeth ………………………..☐
6. Headaches ………………………………☐
7. Lip Biting………………………………☐
8. Mouth Breathing……………………….☐
9. Pain in Jaw Joint………………………☐
10. Sore Teeth……………………………..☐
11. Speech Problems………………………☐
12. Snoring………………………………….☐
13. Speech Problems (specifically) ………☐
14. Tongue Thrusting…………………..☐
15. OTHER ___________________________☐

III. PATIENTS OR PARENTS ATTITUDE TOWARD TEETH CARE AND ORTHODONTIC TREATMENT

A. Regular dental checkups:
- Twice a year
- Once a year
- Only if necessary
- Never

B. Patient’s interest in orthodontic treatment:
- Eager for treatment
- Willing if necessary
- Dreading but agrees
- Unwilling

C. Orthodontic consultation was prompted by:
- Patient (Name)___________________________
- Dentist (Name)___________________________
- Mother
- Father
- Brother
- Sister
- Other relative (Name)_______________________
- Friend (Name)____________________________
- OTHER _____________________________

D. Has the patient ever had any Unusual dental experiences? ………… ☐ ☐
If yes, please explain:____________________________________________________

E. Are there any medical, dental, surgical, Or psychological problems not covered Above? …………………………………… ☐ ☐
If yes, please explain:____________________________________________________

F. Has the patient ever had a previous? Orthodontic consultation or treatment? … ☐ ☐
Name of the Dr.___________________________

G. Why are you seeking this consultation?
- To improve dental appearance
- To improve facial appearance
- To improve general appearance
- To improve longevity of teeth
- To improve self-esteem
- To reduce facial pain
- To reduce headaches/neck aches
- OTHER ________________________________

Comments:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

To the best of my knowledge, all the preceding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that are not reported above, I will inform the doctor at my next visit.

_______________________________________________________________
Patient/Responsible Party’s Signature

_________________________________________________________________________
Date