ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

Name: Date:

I. SUBJECTIVE COMPLAINTS AND CONCERNS

A. What are the patient's or parent's main concerns regarding the jaw and teeth?

1. ☐ Mild Facial Pain	☐ Moderate Facial Pain	☐ Severe Facial Pain
2. ☐ Mild Gum Disease/Recession	☐ Moderate Gum Disease/Recession	☐ Severe Gum Disease/Recession
3. ☐ Mild Gum Problems	☐ Moderate Gum Problems	☐ Severe Gum Problems
4. ☐ Mild Headaches	☐ Moderate Headaches	☐ Severe Headaches
5. ☐ Mild Jaw Dysfunction	☐ Moderate Jaw Dysfunction	☐ Severe Jaw Dysfunction
6. ☐ Mild Jaw Joint Sounds	☐ Moderate Jaw Joint Sounds	☐ Severe Jaw Joint Sounds
7. ☐ Mild Jaw Pain	☐ Moderate Jaw Pain	☐ Severe Jaw Pain
8. ☐ Mild Neck Pain	☐ Moderate Neck Pain	☐ Severe Neck Pain
9. ☐ Mild Ringing or "Stuffy" Ears	☐ Moderate Ringing or "Stuffy" Ears	☐ Severe Ringing or "Stuffy" Ears

☐ Bad Bite	☐ Gummy Smile	☐ Prominent Lower Jaw (too "strong")
☐ "Buck" Teeth / Overjet	☐ Impacted Tooth / Teeth	☐ Protrusion of Teeth
☐ Crowding of Upper Teeth	☐ Improper Tooth Position	☐ Recessive Lower Jaw (too "weak")
☐ Crowding of Lower Teeth	☐ Irregular Facial Proportions	☐ Rotations
☐ Crowding of Upper & Lower Teeth	☐ Irregular Shaped Tooth/ Teeth	☐ Small Teeth
☐ Crossbite	☐ Missing Tooth/Teeth	☐ Spaces
☐ Dentist Recommended Seeing an Orthodontist	☐ Mouth Too Small	☐ Thumb / Finger Habit
☐ Grinding Teeth	☐ Open Bite	☐ Underbite
	☐ Overbite	☐ OTHER:

B. Family members with similar problems:

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ OTHER:

II. MEDICAL DENTAL HISTORY

A. Present Health

1. Physical	☐ Good	☐ Fair	☐ Poor
2. Emotional	☐ Good	☐ Fair	☐ Poor
3. Under Stress	☐ Good	☐ Fair	☐ Poor

B. Has the patient reached puberty? ☐ Yes ☐ No

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

- ☐ Allergies
- ☐ AIDS / ARC / HIV (Circle)
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Disease
- ☐ Bone Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emotional Problems
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Female Problems
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Hearing Disorders
- ☐ Heart Disease / Surgery
- ☐ Hepatitis
- ☐ Herpes / Fever Blisters
- ☐ High Blood Pressure / Low Blood Pressure (Circle)
- ☐ Hospitalized for Any Reason
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Ringing of Ears
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Disturbance
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Trauma (to face, teeth, jaws, or head)
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other:

D. MEDICATIONS

Current medications taken by the patient:

- ☐ Antibiotics
- ☐ Birth Control Pills
- ☐ 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:

E. ALLERGIES TO MEDICATIONS/FOOD

The patient demonstrates an allergic response to:

- ☐ Antibiotics (specifically):
- ☐ Aspirin
- ☐ Codeine
- ☐ Dairy Products
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Food Dyes
- ☐ Jewelry/Metals
- ☐ Latex
- ☐ Pain Pills (specifically):
- ☐ Wheat
- ☐ OTHER:

F. OTHER PERTINENT INFORMATION

Has the patient ever had a history of the following?

1.	☐ Occasionally Colds	☐ Frequently Colds
2.	☐ Occasionally Difficulty Chewing	☐ Frequently Difficulty Chewing
3.	☐ Occasionally Difficulty Swallowing	☐ Frequently Difficulty Swallowing
4.	☐ Occasionally Finger Sucking	☐ Frequently Finger Sucking
5.	☐ Occasionally Grinding Teeth	☐ Frequently Grinding Teeth
6.	☐ Occasionally Headaches	☐ Frequently Headaches
7.	☐ Occasionally Lip Biting	☐ Frequently Lip Biting
8.	☐ Occasionally Mouth Breathing	☐ Frequently Mouth Breathing
9.	☐ Occasionally Pain in Jaw Joint	☐ Frequently Pain in Jaw Joint
10.	☐ Occasionally Smoking	☐ Frequently Smoking
11.	☐ Occasionally Snoring	☐ Frequently Snoring
12.	☐ Occasionally Sore Teeth	☐ Frequently Sore Teeth
13.	☐ Occasionally Sore Throats	☐ Frequently Sore Throats
14.	☐ Occasionally Speech Problems	☐ Frequently Speech Problems
15.	☐ Occasionally Thumb Sucking	☐ Frequently Thumb Sucking
16.	☐ Occasionally Tongue Thrusting	☐ Frequently Tongue Thrusting

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17. ☐ Occasionally Tonsillitis ☐ Frequently Tonsillitis
18. ☐ Occasionally Other Habits: ☐ Frequently Other Habits:

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):
- ☐ Spouse
- ☐ Mother / Father (Circle)
- ☐ Brother / Sister (Circle)
- ☐ Other relative (Name):
- ☐ Friend (Name):
- ☐ OTHER (Name):

D. Has the patient ever had any unusual dental experiences?
☐ No ☐ Yes: If yes, please explain:

E. Are there any medical, dental, surgical, or psychological problems not covered above?
☐ No ☐ Yes: If yes, please explain:

F. Has the patient ever had a previous orthodontic consultation/treatment? ☐ No ☐ Yes

If yes, Name of Doctor:

City, State of Doctor:

G. HEALTH PROFESSIONAL(S) *(Current, or have seen previously)*

1) Doctor Name:

City, State:

Reason(s) for treatment:

(2) Doctor Name:

City, State:

Reason(s) for treatment:

(3) Doctor Name:

City, State:

Reason(s) for treatment:

H. 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 Print Name

Patient/Responsible Party Signature

Date

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