ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

I. SUBJECTIVE COMPLAINTS AND CONCERN

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

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Facial Pain</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Gum Disease/Recession</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Gum Problems</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Headaches</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Jaw Dysfunction</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Jaw Joint Sounds</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. Jaw Pain</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8. Neck Pain</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9. Ringing or “Stuffy” Ears</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

☐ Bad Bite
☐ “Buck” Teeth/Overjet
☐ Crowding of Upper Teeth
☐ Crowding of Lower Teeth
☐ Crowding of Upper and 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>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physical</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Emotional</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Under Stress</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

☐ Yes ☐ No

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
☐ Low 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
☐ 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 Pills (specifically) ______________
- Wheat
- Other ____________________________

F. Other Pertinent Information - Has the patient ever had a history of the following?

1. Clicking in Jaw Joint ............... Occasionally
2. Colds ........................................... Frequently
3. Difficulty Chewing .................. Occasionally
4. Difficulty Swallowing .............. Frequently
5. Finger Sucking ...................... Occasionally
6. Grinding Teeth ...................... Frequently
7. Headaches ................................. Occasionally
8. Lip Biting ................................. Frequently
9. Mouth Breathing ..................... Occasionally
11. Smoking ................................. Occasionally
12. Snorting .................................. Frequently
13. Sore Teeth ............................... Occasionally
14. Sore Throats ............................. Frequently
15. Speech Problems ..................... Occasionally
16. Thumb Sucking ....................... Frequently
17. Tongue Thrusting .................... Occasionally
18. Tonsilitis ................................. Frequently
19. Other Habits .............................. Occasionally
20. 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
- Spouse
- Brother
- Sister
- Other relative (Name) ____________________________
- Friend (Name) ____________________________
- Other ____________________________

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

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

F. Has the patient ever had a previous orthodontic consultation or treatment? Yes No
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/neckaches
- 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 medication that are not reported above, I will inform the doctor at my next visit.

____________________________________________
Patient/ Responsible Party’s Signature

____________________________________________
Date