

# 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 .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Gum Disease/Recession	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Gum Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Headaches .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Jaw Dysfunction .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Jaw Joint Sounds .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Jaw Pain .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Neck Pain .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ringing or "Stuff" Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 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	Good	Fair	Poor
1. Physical .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Emotional .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Under Stress .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 \_\_\_\_\_

**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?**

- |                                |                          |                          |
|--------------------------------|--------------------------|--------------------------|
|                                | Occasionally             | Frequently               |
| 1. Clicking in Jaw Joint ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Colds .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Difficulty Chewing .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Difficulty Swallowing ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Finger Sucking .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Grinding Teeth .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Headaches .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Lip Biting .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Mouth Breathing .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Pain in Jaw Joint .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Smoking .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Snorting .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Sore Teeth .....           | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Sore Throats .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Speech Problems .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Thumb Sucking .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Tongue Thrusting .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Tonsillitis .....          | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Other Habits .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. OTHER _____                | <input type="checkbox"/> | <input type="checkbox"/> |

**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 \_\_\_\_\_

Yes      No

D. Has the patient ever had any unusual dental experiences? .....      

If yes, please explain: \_\_\_\_\_

Yes      No

E. Are there any medical, dental, surgical, or psychological problems not covered above?      

If yes, please explain: \_\_\_\_\_

Yes      No

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/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