

ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

NAME _____

I. SUBJECTIVE COMPLAINTS AND CONCERNS

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

- | | Mild | Moderate | Severe |
|---|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> 1. Facial Pain..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 2. Gum Disease/Recession | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 3. Gum Problems..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 4. Headaches..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 5. Jaw Dysfunction..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 6. Jaw Joint Sounds..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 7. Jaw Pain..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 8. Neck Pain..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 9. Ringing or "Stuff" Ears... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bad Bite | | | |
| <input type="checkbox"/> "Buck" Teeth/ Overjet | | | |
| <input type="checkbox"/> Crowding of Upper Teeth | | | |
| <input type="checkbox"/> Crowding of Lower Teeth | | | |
| <input type="checkbox"/> Crowding of Upper and Lower Teeth | | | |
| <input type="checkbox"/> Crossbite | | | |
| <input type="checkbox"/> Dentist Recommended Seeing an Orthodontist | | | |
| <input type="checkbox"/> Grinding Teeth | | | |
| <input type="checkbox"/> Gummy Smile | | | |
| <input type="checkbox"/> Impacted Tooth/ Teeth | | | |
| <input type="checkbox"/> Improper Tooth Position | | | |
| <input type="checkbox"/> Irregular Facial Proportions | | | |
| <input type="checkbox"/> Irregular Shaped Tooth/ Teeth | | | |
| <input type="checkbox"/> Missing Tooth/ Teeth | | | |
| <input type="checkbox"/> Mouth Too Small | | | |
| <input type="checkbox"/> Open Bite | | | |
| <input type="checkbox"/> Overbite | | | |
| <input type="checkbox"/> Prominent Lower Jaw (too 'strong') | | | |
| <input type="checkbox"/> Protrusion of Teeth | | | |
| <input type="checkbox"/> Recessive Lower Jaw (too 'weak') | | | |
| <input type="checkbox"/> Rotations | | | |
| <input type="checkbox"/> Small Teeth | | | |
| <input type="checkbox"/> Spaces | | | |
| <input type="checkbox"/> Thumb/ Finger Habit | | | |
| <input type="checkbox"/> Underbite | | | |
| <input type="checkbox"/> OTHER _____ | | | |

B. Family members with similar problems:

- Patient Adopted
- Father
- Mother
- Brother
- Sister
- OTHER _____

II. MEDICAL DENTAL HISTORY

- | | Good | Fair | Poor |
|----------------------|--------------------------|--------------------------|--------------------------|
| A. Present Health | | | |
| 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"/> |

- | | Yes | No |
|-------------------------------------|--------------------------|--------------------------|
| B. Has the patient reached puberty? | <input type="checkbox"/> | <input type="checkbox"/> |

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
- GERD (Acid Reflux)
- Hearing Disorders
- Heart Disease
- Hepatitis
- HIV/AIDS/ARC (Circle)
- Kidney Disease
- Latex Allergy
- 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 (Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Zometa, etc.)
- Diet Pills (diuretics)
- Heart Pills (digitalis, etc.)
- Insulin
- Muscle Relaxants (valium, etc.)
- Pain Pills (demerol, codeine, etc.)
- Sleeping Pills
- Tranquilizers or Antidepressants (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. Snoring..... | <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 _____

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 _____

G. Date of Last Dental Exam (mm/yy) _____

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

Submit