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

- ☐ 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
- ☐ Grinding Teeth
- ☐ 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:

- ☐ Patient Adopted
- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ OTHER_____

II. MEDICAL DENTAL HISTORY

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

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

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_____

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?

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

	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_____

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