

# 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"/> |
| <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"/> 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:**

- 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
<input type="checkbox"/>	<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
- Dizziness
- Emotional Problems
- Endocrine Problems
- Epilepsy
- Female Problems
- Hearing Disorders
- Heart Disease
- 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 \_\_\_\_\_

Yes      No

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

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

**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/Nail 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"/> |

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 \_\_\_\_\_

**H. Physician's Name;** \_\_\_\_\_

**Comments:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, all the preceding answers are true and correct. If deemed advisable, I grant permission for my health care provider's 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

\_\_\_\_\_  
Orthodontist's Signature      Date

**III. PATIENTS OR PARENTS ATTITUDE TOWARD TEETH CARE AND OTHODONTIC 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
<b>D. Has the patient ever had any unusual dental experiences?.....</b>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		