

**PATIENT HEALTH QUESTIONNAIRE FOR: Full Name** \_\_\_\_\_

Please complete both pages of this health questionnaire as fully and completely as possible, writing in any other information you feel would be helpful. Your confidentiality will be respected.

**CHIEF CONCERN(S):**

- Crowded teeth
- 
- Over bite
- 
- Buck teeth
- 
- Receded jaw
- 
- Gummy smile
- 
- Spacing between teeth
- 
- Gum disease/recession
- 
- Missing teeth
- 
- Jaw dysfunction
- 
- Mouth too small
- 
- Clicking jaw joint
- 
- Irregular teeth
- 
- Protrusion of teeth
- 
- Ears Ring/Stuffy
- 
- Headache/Face pain
- 
- Neck pain
- 
- Jaw pain
- 
- Irregular facial appearance
- 

Other:  
\_\_\_\_\_

**FAMILY MEMBERS WITH SIMILAR CONDITION:**

- Father    Mother    Brother    Sister

Other:  
\_\_\_\_\_

**PARENTS' MARITAL STATUS**

**(if patient is a minor):**

- Married    Divorced    Seperated    Single

Widowed

Other  
\_\_\_\_\_

**PATIENT'S CURRENT PHYSICAL HEALTH:**

- Excellent                       Good  
 Fair                                       Poor

**PATIENT'S CURRENT EMOTIONAL HEALTH:**

- Excellent                       Good  
 Fair                                       Poor

**KNOWN OR SUSPECTED ALLERGIES:**

Antibiotics:  
\_\_\_\_\_

Pain pills:  
\_\_\_\_\_

Foods:  
\_\_\_\_\_

Environmental allergies:  
\_\_\_\_\_

None

**PLEASE INITIAL**

\_\_\_\_\_

**CONDITIONS THE PATIENT HAS OR HAS HAD:**

- AIDS
- Allergies
- Asthma
- Autoimmune disorders
- Blood disease
- High blood pressure
- Low blood pressure
- Bone disorders
- Cancer
- Diabetes
- Dizziness
- Eating disorders
- Endocrine problems
- Emotional problems
- Female problems
- HIV positive status
- Hepatitis
- Heart disease
- Heart murmur
- Hearing disorder
- Kidney disease
- Rheumatic fever
- Ringing of the ears
- Sleep disturbance
- Kidney disease
- History of trauma

- Teeth    Face    Jaws    Head

- None of the Above

PLEASE INITIAL

**CURRENT MEDICATIONS:**

- Heart pills

Antibiotics:

- Diet pills

Pain pills:

- Vitamins

- Birth control pills

- Muscle relaxants

- Insulin

Other:

- None

PLEASE INITIAL

**HAS (CHILD) PATIENT REACHED PUBERTY:**

Yes, approximate date:

- No

**PRIMARY BREATHING PATTERN:**

- Mouth    Nose

Depends on:

**DOES THE PATIENT SNORE WHEN SLEEPING?**

- Yes    No

Sometimes:

**DIFFICULTY CHEWING?**

- Yes

- Teeth don't meet well

-  Pain when chewing

-  Other

- No

**CHECK ALL THAT APPLY:**

- Frequent sore throat/tonsillitis
- Speech problems
- Pain in the RIGHT jaw joint
- Pain in the LEFT jaw joint
- Clicking/popping in RIGHT jaw
- Clicking/popping in LEFT
- Current thumb/finger sucking habit
- Previous thumb/finger sucking habit
- Lip biting/sucking habit
- Grind teeth
- Clench jaws
- Tongue thrust when

**HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAM/CONSULTATION?**

- Yes
- No

**FREQUENCY OF DENTAL CHECKUPS?**

- Once per year
- Twice per year
- More than twice a year
- Emergencies only
- Never

**PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?**

- Wants treatment
- Only if necessary
- Unwilling But will cooperate if treatment is needed
- Uncooperative

**ORTHODONTIC EXAM PROMPTED BY:**

- Patient       Mother       Spouse
- Dentist       Father       Sibling
- Doctor       Friend       Other

**MEDICAL, DENTAL, OR SURGICAL PROBLEMS NOT COVERED ON THIS FORM?**

- Yes, please describe:

Printed Name \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_