**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_____/____/_____