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_____/____/_____