HEALTH QUESTIONNAIRE

Patient Name______________________________ Date____________

MEDICAL HISTORY: The following conditions are of interest to the orthodontist:

1. Has the patient ever had:

yes	no		yes	no	
☐	☐	Allergic reactions to medicine?	☐	☐	Heart problems?
☐	☐	Bleeding disorders?	☐	☐	Hepatitis or liver disease?
☐	☐	Bone disorders?	☐	☐	HIV?
☐	☐	Diabetes?	☐	☐	Rheumatic fever?
☐	☐	Epilepsy?	☐	☐	Serious recurrent illness?
☐	☐	Endocrine problems?	☐	☐	Tuberculosis?
☐	☐	Growth disorders?	☐	☐	Venereal diseases?

2. Is the patient now:

☐ ☐ Under physicians care? For?______________________________

☐ ☐ Taking medicine? Please list: ______________________________

☐ ☐ Using tobacco?

3. Patient's Height ______ Mother's Ht ______ Father's Ht ______

4. Please list any medical or surgery problems not covered above:
   Comments:

DENTAL HISTORY: The following conditions are of interest to the orthodontist:

Airway:

1. Does the patient have:

☐ ☐ Allergies ? - to ______________________________

☐ ☐ Frequent Sinusitis?

☐ ☐ Frequent tonsilitis, ear infections or sore throats?

☐ ☐ Frequent difficulty breathing through nose?

☐ ☐ A mouth breathing tendency?

☐ ☐ Tonsils and adenoids present? Removed at age_____

Oral Habits:

2. Has the patient ever had:

☐ ☐ Habit of ☐ thumb, ☐ finger, or ☐ tongue sucking? - until age ____

☐ ☐ Habit of lip sucking or biting ?

☐ ☐ Tendency to rest the tongue between the teeth?

☐ ☐ Tongue thrusting tendency when swallowing or talking?

☐ ☐ Speech therapy or speech problems? - until age ____

☐ ☐ Are any of the above habits still present? ______________________

Comments:

over

Temporomandibular Joint:

3. Does the patient have:

yes	no	
☐	☐	Tenderness, clicking or popping on jaw movements?
☐	☐	Difficulty opening or closing mouth?
☐	☐	Frequent headaches, neckaches or face pain?
☐	☐	Tendency to grind or clench teeth at night?
☐	☐	Past whiplash or injuries to head, jaw, or neck?
		Comments:

Orthodontic History:

4. Has the patient:

yes	no	
☐	☐	Had teeth broken, loosened, or lost due to a severe blow to the teeth?
☐	☐	Been told of having teeth missing?
☐	☐	Been told of having extra teeth?
☐	☐	Had to have any ☐ baby teeth or ☐ permanent teeth removed by a dentist?
☐	☐	Had space maintainers, retainers or orthodontic treatment in the past? Please explain:
☐	☐	Consulted another orthodontist about the present concern?
☐	☐	Had concerns or reservations about orthodontic treatment - about wearing braces, retainers, or headgear if needed? Please explain:
☐	☐	Any other family members who have worn braces?

5. Does the patient likely:

☐	☐	Need a preorthodontic, routine 6 month checkup?
☐	☐	Need any fillings or dental work?
☐	☐	Need to improve tooth brushing effectiveness?

6. What is the patient's (or parent's) primary orthodontic concern (what you would like to have orthodontic treatment accomplish)? ____________________

7. Is the patient interested in the appearance of his/her teeth and in getting them straightened? ☐ yes ☐ no ☐ probably ☐ undecided

8. Please make any other comments you feel may be helpful:

Thank you for taking the time to complete these forms.