

# 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                       |                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic reactions to medicine? | <input type="checkbox"/> | <input type="checkbox"/> | Heart problems?             |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding disorders?             | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or liver disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone disorders?                 | <input type="checkbox"/> | <input type="checkbox"/> | HIV?                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes?                       | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever?            |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy?                       | <input type="checkbox"/> | <input type="checkbox"/> | Serious recurrent illness?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine problems?             | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis?               |
| <input type="checkbox"/> | <input type="checkbox"/> | Growth disorders?               | <input type="checkbox"/> | <input type="checkbox"/> | 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 tonsillitis, 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:

### 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.