

DATE: _____

PATIENT HEALTH QUESTIONNAIRE FOR: _____ DDS: _____

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
- Prominent 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
- Separated 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
- Chemotherapy
- Diabetes
- Dizziness
- Eating disorders
- Early Menopause
- Endocrine problems
- Emotional problems
- Female problems
- HIV positive status
- Hepatitis
- Heart disease
- Heart murmur
- Hearing disorder
- Kidney disease
- Menopause
- Osteoporosis
- Rheumatic fever
- Ringing of the ears
- Sleep disturbance
- History of trauma
- Teeth Face Jaws Head
- None of the Above _____ PLEASE INITIAL

CURRENT MEDICATIONS:

- Heart pills
 - Antibiotics: _____
 - Diet pills
 - Pain pills: _____
 - Osteoporosis Medication – Bisphosphonates (Fosamax, Actonel, Didronel, Boniva, Aredia, Zometa, Skelid)
 - 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 joint
- Clicking/popping in LEFT jaw joint
- Current thumb/finger sucking habit
- Previous thumb/finger sucking habit
- Lip biting/sucking habit
- Grind teeth
- Clench jaws
- Tongue thrust when swallowing

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: _____
- _____
- _____
- _____
- _____

Responsible Party Signature

Printed Name

Date

DOCTOR'S NOTES:
