VILLAGE ORTHODONTICS

Orthodontic Patient Health Questionaire

Date _____

Patient Name _____

I. Subjective Concerns

A. What are the patient's or parent's main concerns regarding the jaw and teeth

- ☐ Dentist Recommended Seeing an Orthodontist
- ☐ Crowding of Upper Teeth
- ☐ Crowding of Lower Teeth
- ☐ "Buck" Teeth/Overjet
- ☐ Overbite
- ☐ Underbite
- ☐ Spaces
- ☐ Bad Bite
- ☐ Crossbite
- ☐ Grinding Teeth
- ☐ Gummy Smile
- ☐ Impacted Tooth/Teeth
- ☐ Improper Tooth Position
- ☐ Irregular Facial Proportions
- ☐ Irregular Shaped Tooth/Teeth
- ☐ Missing Tooth/Teeth
- ☐ Mouth Too Small
- ☐ Open Bite
- ☐ Prominent Lower Jaw (too "strong")
- ☐ Protrusion of Teeth
- ☐ Recessive Lower Jaw (too "weak")
- ☐ Rotations
- ☐ Small Teeth
- ☐ Thumb/Finger Habit
- ☐ Other_____

B. Family Members with similar problems

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ OTHER _____

C. Other Pertinent Information
(Has the patient ever had a history of the following?):

- ☐ Difficulty Chewing
- ☐ Difficulty Swallowing
- ☐ Finger/Thumb Sucking
- ☐ Grinding Teeth
- ☐ Headaches
- ☐ Lip Biting
- ☐ Mouth Breathing
- ☐ Pain in Jaw Joint
- ☐ Snoring
- ☐ Speech Problems
- ☐ Tongue Thrusting
- ☐ Tonsilitis
- ☐ OTHER

II. Medical History

A. Medications (current medications taken by the patient):

_____

_____

B. Allergies to Medications/Food (the patient displays an allergic response to):

- ☐ Jewelry/Metals
- ☐ Latex
- ☐ Aspirin
- ☐ Codeine
- ☐ Antibiotics (List) _____
- ☐ OTHER _____

C. Has the patient ever had any of the following conditions?

- ☐ Allergies
- ☐ AIDS/HIV (Circle)
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Disease
- ☐ Bone Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hearing Disorders
- ☐ Hospitalized for Any Reason
- ☐ Heart Murmer
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Ringing of Ears
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Thyroid Problems
- ☐ Trauma (to face, teeth,jaws, or head)
- ☐ Ulcers

D. Are there any medical, dental, surgical or psychological problems not covered above? NO / YES If yes, please explain

_____

_____

III. Patient's or Parent's attitude toward dental care and orthodontic treatment.

Patient's general dentist _____

Town, State _____

Last visit for cleaning/exam _____

Any work still needing to be completed? YES / NO

A. Regular dental check ups: ☐ Twice a year ☐ Once a year ☐ Only if necessary ☐ None

B. Patient's attitude towards orthodontic treatment:

_____

_____

C. Has the patient ever had any unusual dental experiences?

_____

D. Has the patient ever had a previous orthodontic consultation/treatment? No / YES If yes, Name of Doctor

_____

E. Why are you seeking this consultation?

_____

_____

To the best of my knowledge, all the proceeding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that are not reported above, I will inform the doctor at my next visit.

_____

Patient/Responsible Party's Signature Date