

# ORTHODONTIC - HEALTH QUESTIONNAIRE and PATIENT INFORMATION

## DRS. HOFFMAN & WOLK

PATIENT  
NUMBER

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NAME: \_\_\_\_\_ (FIRST) \_\_\_\_\_ (LAST) DATE OF BIRTH: \_\_\_\_\_ DATE: \_\_\_\_\_  
M / D / Y M / D / Y

**A. What are the patients or parents main concerns regarding the jaws and teeth?**

- 1 Crowding
- 2 Over-bite
- 3 "Buck" teeth
- 4 Receded jaw
- 5 Prominent jaw
- 6 Gummy smile
- 7 Spaces
- 8 Gum disease / recession
- 9 Missing teeth
- 10 Jaw dysfunction
- 11 Mouth too small
- 12 Clicking jaw joint
- 13 Irregularly shaped teeth
- 14 Protrusion of teeth
- 15 Ringing / Stiffness of ears
- 16 Headaches / Facial pain
- 17 Neck pain
- 18 Jaw pain
- 19 Irregular facial proportions
- 20 General appearance

**B. MEDICAL HISTORY**

- 1. Present health**
- |                    | Good | Fair | Poor |
|--------------------|------|------|------|
| a. Physical .....  | 1    | 2    | 3    |
| b. Emotional ..... | 1    | 2    | 3    |

- 2. If a child; has patient reached puberty?** Yes  No

**3. Has the patient ever had any of the following conditions?**

- A Allergies
- B Arteriosclerosis
- C Asthma
- D Autoimmune disorder
- E Blood disease
- F High Blood Pressure
- G Low Blood Pressure
- H Bone disorders
- I Cancer
- J Diabetes
- K Dizziness
- L Epilepsy
- M Endocrine problems
- N Emotional problems
- P Hepatitis
- Q Heart disease
- R Hearing disorder
- S Kidney disease
- T Rheumatic fever
- U Ringing of ears
- V Sleeping disturbance
- W Received trauma (teeth, face, jaws, or head)
- X Other \_\_\_\_\_

**4. MEDICATIONS: Current medications taken by the patient:**

- 1 Heart pills (digitalis, etc.)
- 2 Antibiotics
- 3 Diet pills (diuretics)
- 4 Pain pills (demerol, codeine, etc.)
- 5 Vitamins
- 6 Birth control pills
- 7 Sleeping pills
- 8 Muscle relaxants
- 9 Insulin
- 10 Other \_\_\_\_\_

**5. ALLERGIES TO MEDICATIONS / FOOD:**

- The patient demonstrates an allergic response to:**
- 1 Antibiotics (specific)
  - 2 Pain pills (codeine, etc.)
  - 3 Dairy products
  - 4 Wheat, cereals
  - 5 Dyes in food
  - 6 Other \_\_\_\_\_

**C. DENTAL HISTORY**

The following are also of interest to the orthodontist.  
Does the patient:

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Snore when sleeping? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Breathe through the mouth? (mouth breather rather than nose breather) |                          |                          |
| A Seldom   |                          |                          |
| B Sometimes  |                          |                          |
| C Usually  |                          |                          |
| 3. Have pain in the jaw joint? ..  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have clicking in jaw joint? ..  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have speech problems? .....   | <input type="checkbox"/> | <input type="checkbox"/> |

**D. The following habits are of interest to the orthodontist:**

- |                                 | Yes                      | No                       |
|---------------------------------|--------------------------|--------------------------|
| 1. Thumb sucking                |                          |                          |
| A Never                         |                          |                          |
| B Previous                      |                          |                          |
| C Presently                     |                          |                          |
| 2. Finger sucking               |                          |                          |
| A Never                         |                          |                          |
| B Previous                      |                          |                          |
| C Presently                     |                          |                          |
| 3. Lip biting or sucking? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Grinding of teeth? .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Tongue thrusting? .....      | <input type="checkbox"/> | <input type="checkbox"/> |

6. Other habits? .....

**E. PATIENT'S ATTITUDE TOWARD TEETH, FACE, AND ORTHODONTIC TREATMENT:**

- 1. Dental checkups**
- A Twice a year
  - B Once a year
  - C Only if urgent
  - D Never
- 2. Is patient aware of any orthodontic problem? .....**
- 3. Patient's interest in orthodontic treatment:**
- A Wants treatment
  - B Treatment if necessary
  - C Unwilling but agrees
  - D Uncooperative

**4. Orthodontic consultation prompted by:**

- A Patient
- B Dentist
- C Mother
- D Father
- E Spouse
- F Sibling
- G Physician
- H Friend
- I Other

5. Has the patient had previous orthodontic consultation or treatment? ..... Yes No

6. Has the patient had any unusual dental experiences?

F. Are there any medical, dental or surgical problems not covered above? .....

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