PATIENT HEALTH QUESTIONNAIRE:

CHECK ALL THAT APPLY:

1. Are you in good health?__________________
2. Have there been changes in your general health within the past year?_____________________
3. Date of your last exam?___________________
4. Physician's name________________________
   Address_______________________________
   Phone No._____________________________
5. Are you now under a physicians care________
6. Have you ever been hospitalized for any surgical operation or serious illness?________________
7. Have you ever taken Fen-Phen/Redux?____

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
_ Headache/Face pain
_ Neck pain
_ Jaw pain
_ Other: ________________________________

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 or talking

PRIMARY BREATHING PATTERN:

_ Mouth _ Nose
_ Depends on ____________________________

DOES THE PATIENT SNORE WHEN SLEEPING?

_ Yes _ No
_ Sometimes: _____________________

Dentist:_________________________________
Phone No._______________________________

FREQUENCY OF DENTAL CHECK UPS:

_ Once a year
_ Twice a year
_ More than twice a year
_ emergencies only
_ Never

FAMILY MEMBERS WITH SIMILAR CONDITION:

_ Father _ Mother _ Brother _ Sister
_ Other:_________________________

PATIENT'S CURRENT EMOTIONAL HEALTH:

_ Excellent _ Good
_ Fair _ Poor

HAS (CHILD) PATIENT REACHED PUBERTY:

_ Yes, approximate date: ______________________
No

DIFFICULTY CHEWING?

_ Yes
  _ Teeth don't meet well
  _ Pain when chewing
  _ Other:
  _ No

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

HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAM/CONSULTATION?

_ Yes: _____________________
_ No

CONDITIONS THE PATIENT HAS OR HAS HAD:

_ AIDS or HIV infection
_ Anemia
_ Arthritis or rheumatism
_ Asthma
_ Autoimmune disorders
_ Blood disease
_ High blood pressure
_ Low blood pressure
_ Bone disorders
_ Cancer
_ Diabetes
_ Dizziness/Seizures/Fainting spells
_ Eating disorders
_ Endocrine problems
_ Emotional problems
_ Epilepsy
_ Glaucoma
_ High blood pressure
_ Hepatitis, jaundice or liver disease
_ Heart disease, heart attack or angina
_ Heart murmur or defect
_ Heart surgery
_ Hearing disorder
_ Joint replacement or implant
_ Kidney disease/problems
_ Leukemia
_ Low blood pressure
_ Lung or breathing problems
_ Pace maker
_ Persistent cough / cough that produces blood
_ Rheumatic fever
_ Ringing of the ears
_ Scarlet fever
_ Sexually transmitted disease
_ Sinus trouble
_ Sleep disturbance
_ Stomach ulcer
_ Stroke
_ Thyroid problems
_ Tuberculosis
_ History of trauma
_ Teeth _ Face _ Jaws _ Head
_ None of the Above

_______ PLEASE INITIAL

KNOWN OR SUSPECTED ALLERGIES:

_ Antibiotics: ________________________
_ Pain pills: ________________________________
_ Foods: ___________________________________
_ Environmental allergies: _____________________
_ Hives or skin rash:_____________________
_ Hay Fever:__________________________
_ Barbiturates, sedatives or sleeping pills_____
_ None

_______ PLEASE INITIAL

CURRENT MEDICATIONS:

_ Heart pills:______________________________
_ Antibiotics: _______________________________
_ Diet pills:_______________________________
_ Pain pills: ______________________________
_ Vitamins:________________________________
_ Birth control pills:_______________________
_ Muscle relaxants:_________________________
_ Insulin:__________________________________
_ Other: ___________________________________
_ None

_______ PLEASE INITIAL

MEDICAL, DENTAL, OR SURGICAL PROBLEMS NOT COVERED ON THIS FORM?

_No _Yes, please describe: ___________________________

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Responsible Party Signature	Date

DOCTOR'S NOTES:

____

____

Summary of Dental History:

____

____

Summary of Medical History:

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