Patient Health Questions

Patient's Name: _____ _____
(First Name) (Last Name)

		Yes	No	Not Sure
1.	Is there a history in your family of: irregular teeth?	☐	☐	☐
	protruding teeth?	☐	☐	☐
	congenitally missing teeth?	☐	☐	☐
2.	Has any (other) member of your family had orthodontic treatment?	☐	☐	☐
3.	Is your orthodontic problem obvious to you?	☐	☐	☐
4.	Are you satisfied with the appearance of your teeth?	☐	☐	☐
5.	Do you have frequent indigestion?	☐	☐	☐
6.	Do you play any wind instruments?	☐	☐	☐
7.	Have you had any severe accidents involving your: teeth?	☐	☐	☐
	jaws?	☐	☐	☐
	lips?	☐	☐	☐
8.	Do you have frequent: sore throats?	☐	☐	☐
	colds?	☐	☐	☐
	asthma?	☐	☐	☐
	hay fever?	☐	☐	☐
	other allergies?	☐	☐	☐
9.	Do you often notice that you are breathing through your mouth?	☐	☐	☐
10.	Are your tonsils or adenoids present?	☐	☐	☐
11.	Have you had any teeth extracted: because of decay?	☐	☐	☐
	to make room for permanent teeth?	☐	☐	☐
	because of gum disease?	☐	☐	☐
12.	Have you had any previous orthodontic treatment or consultations?	☐	☐	☐
13.	Are you in good general health?	☐	☐	☐

14. Have you had any of the following?

Heart trouble	☐	Muscular dystrophy	☐
Tuberculosis or any lung disease	☐	Multiple sclerosis	☐
Mental or nervous disease	☐	Cancer	☐
Sinusitis	☐	Venereal disease	☐
Hepatitis, jaundice or liver disease	☐	Gall bladder disease	☐
		Speech problems	☐
Psychiatric disorders	☐	Epilepsy	☐
Arthritis	☐	Anaemia	☐
Kidney disease	☐	AIDS or HIV positive	☐
Rheumatic fever	☐	Sleep Apnea	☐
Blood disorders	☐	Thyroid disease	☐
Diabetes	☐	Malignant hyperthermia	☐
Abnormal blood pressure	☐		

		Yes	No	Not Sure
15.	Are you taking any medicine or drugs at the present time?	☐	☐	☐

16. Have you experienced any unusual reaction to any of the following drugs?
penicillin ☐ sulphanamide (Sulfa) ☐ aspirin ☐ codeine ☐
iodine ☐ barbiturates (sleeping pills) ☐ other medicine _____

		Yes	No	Not Sure
17.	Are you allergic to latex:	☐	☐	☐

18. Have you ever fainted? ☐ Yes ☐ No
19. Do your ankles swell? ☐ Yes ☐ No
20. Do you have shortness of breath? ☐ Yes ☐ No
21. Any pains in your chest? ☐ Yes ☐ No

22. Have you had any unexplained weight loss, an increased thirst, appetite or frequency of urination?
23. Do you bruise or bleed abnormally?
24. Are you pregnant?
25. Is there anything that the orthodontist should know regarding your medical or dental history (background) that has not been mentioned (use back of page if necessary) ... ☐ Yes ☐ No

_____

_____ X _____
(Date) Signature