Patient Health Questions

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

Question		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 child's orthodontic problem obvious to you?		☐	☐	☐
4. Is your child becoming self-conscious because of his or her teeth?		☐	☐	☐
5. Does your child have frequent indigestion?		☐	☐	☐
6. Did your child suck his or her thumb during:	infancy?	☐	☐	☐
	after age 3?	☐	☐	☐
	after age 7?	☐	☐	☐
7. Does your child play any wind instruments?		☐	☐	☐
8. Has your child had any severe accidents involving his or her:	teeth?	☐	☐	☐
	jaws?	☐	☐	☐
	lips?	☐	☐	☐
9. Does your child have frequent:	sore throats?	☐	☐	☐
	colds?	☐	☐	☐
	asthma?	☐	☐	☐
	hayfever?	☐	☐	☐
	other allergies?	☐	☐	☐
10. Do you often notice that your child is breathing through his/her mouth?		☐	☐	☐
11. Has your child had his/her tonsils or adenoids removed?		☐	☐	☐
12. Has your child had any baby teeth extracted: because of decay?		☐	☐	☐
13. If baby teeth were extracted were space maintainers used to prevent closing of the extraction space?		☐	☐	☐
14. Has your child had any previous orthodontic treatment or consultations?		☐	☐	☐
15. Is your child in good general health?		☐	☐	☐

16. Has your child had any of the following?

Heart trouble	☐	Abnormal blood pressure	☐
Lung disease	☐	Muscular dystrophy	☐
Kidney disease	☐	Speech problems	☐
Rheumatic fever	☐	Epilepsy	☐
Hepatitis, jaundice or liver disease	☐	Anaemia	☐
Blood disorders	☐	AIDS or HIV positive	☐
Sinusitis	☐	Thyroid disease	☐
Diabetes	☐	Malignant hyperthermia	☐

Question	Yes	No	Not Sure
17. Is your child taking any medicine or drugs at the present time?	☐	☐	☐

18. Has your child experienced any unusual reaction to any of the following drugs?
Penicillin ☐ Aspirin ☐ codeine ☐ other medicine ____________________

____

Question	Yes	No	Not Sure
19. Is your child allergic to latex	☐	☐	☐
20. Is there anything that the orthodontist should know regarding your child's medical or dental history (background) that has not been mentioned	☐	☐	☐

____
____
____

____________________ X ______________________________
(Date) (Parent/Guardian's Signature)

Great Smiles Start Here