HEALTH QUESTIONNAIRE FOR:

Name: _____ DOB: ___/___/____ Age: _____
Dentist: _____ School District: _____

Please complete this health questionnaire as fully and completely as possible, add any other information you feel would be helpful. **Circle all that apply.**

CHIEF CONCERN(S):
Crowded teeth
Over bite
Protrusion of teeth
Receded jaw
Prominent jaw
Gummy smile
Spacing between teeth
Missing teeth
Mouth too small
Clicking jaw joint
Irregular teeth
Headache/Face pain
Neck pain
Jaw pain
Irregular facial appearance
Other: _____

KNOWN OR SUSPECTED ALLERGIES:
Medications: _____
Latex: ___ Nickel___ Other: ___

CHECK ALL THAT APPLY:
Frequent sore throat/tonsillitis
Speech problems
Pain in the jaw
Clicking/popping jaw
Current thumb/finger sucking habit
Previous thumb/finger sucking habit
Lip biting/sucking habit
Grind teeth
Clench jaws
Tongue thrust when swallowing
Ringing of the ears

FREQUENCY OF DENTAL CHECKUPS?
___ Times per year __ Emergencies only __ Never

PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?
-Wants treatment -Only if necessary
-Unwilling-but will cooperate -Uncooperative

CONDITIONS THE PATIENT HAS OR HAS HAD:
Allergies
Asthma
Autoimmune disorders
Blood disease
High blood pressure
Low blood pressure
Bone disorders
Cancer
Diabetes
Dizziness
Eating disorders
Endocrine problems
Emotional problems
HIV positive, AIDS
Hepatitis
Heart disease
Heart murmur
Hearing disorder
Kidney disease
Rheumatic fever
Sleep disturbance
Trauma to: Teeth Face Jaws Head (**Circle)**

CURRENT MEDICATIONS: _____
_____

HAS (CHILD) PATIENT REACHED PUBERTY?
Yes, approximate date: _____
No

HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAM/CONSULTATION?
Yes
No

MEDICAL, DENTAL, OR SURGICAL PROBLEMS NOT COVERED ON THIS FORM?
Yes, please describe: _____
_____

_____ _____ _____
Responsible Party Signature Printed Name Date