Please complete both pages of this health questionnaire as fully and completely as possible, writing in any other information you feel would be helpful. Your confidentiality will be respected.

**CHIEF CONCERN(S):**
- [ ] Crowded teeth
- [ ] Over bite
- [ ] Buck teeth
- [ ] Receded jaw
- [ ] Gummy smile
- [ ] Spacing between teeth
- [ ] Gum disease/recession
- [ ] Missing teeth
- [ ] Jaw dysfunction
- [ ] Mouth too small
- [ ] Clicking jaw joint
- [ ] Irregular teeth
- [ ] Protrusion of teeth
- [ ] Ears Ring/Stuffy
- [ ] Headache/Face pain
- [ ] Neck pain
- [ ] Jaw pain
- [ ] Irregular facial appearance

Other:

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**PATIENT'S CURRENT PHYSICAL HEALTH:**
- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

**PATIENT'S CURRENT EMOTIONAL HEALTH:**
- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

**KNOWN OR SUSPECTED ALLERGIES:**

- **Antibiotics:**
- **Pain pills:**
- **Foods:**
- **Environmental allergies:**
  - [ ] None

**PLEASE INITIAL**

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**FAMILY MEMBERS WITH SIMILAR CONDITION:**
- [ ] Father
- [ ] Mother
- [ ] Brother
- [ ] Sister

Other:

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**PARENTS’ MARITAL STATUS**
(if patient is a minor):
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Single
- [ ] Widowed

Other:

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CONDITIONS THE PATIENT HAS OR HAS HAD:
- AIDS
- Allergies
- Asthma
- Autoimmune disorders
- Blood disease
- High blood pressure
- Low blood pressure
- Bone disorders
- Cancer
- Diabetes
- Dizziness
- Eating disorders
- Endocrine problems
- Emotional problems
- Female problems
- HIV positive status
- Hepatitis
- Heart disease
- Heart murmur
- Hearing disorder
- Kidney disease
- Rheumatic fever
- Ringing of the ears
- Sleep disturbance
- Kidney disease
- History of trauma
  - Teeth
  - Face
  - Jaws
  - Head
  - None of the Above

PLEASE INITIAL

CURRENT MEDICATIONS:
- Heart pills
- Antibiotics:
- Diet pills
- Pain pills:
- Vitamins
- Birth control pills
- Muscle relaxants
- Insulin
- Other:
- None

PLEASE INITIAL

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

PRIMARY BREATHING PATTERN:
- Mouth
- Nose
- Depends on:

DOES THE PATIENT SNORE WHEN SLEEPING?
- Yes
- No
- Sometimes:

DIFFICULTY CHEWING?
- Yes
  - Teeth don't meet well
  - Pain when chewing
  - Other
  - No
  - None of the Above
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
☐ Clicking/popping in LEFT jaw
☑ Current thumb/finger sucking habit
☐ Previous thumb/finger sucking habit
☐ Lip biting/sucking habit
☐ Grind teeth
☐ Clench jaws
☐ Tongue thrust when swallowing

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

FREQUENCY OF DENTAL CHECKUPS?
☐ Once per year
☐ Twice per year
☐ More than twice a year
☐ Emergencies only
☐ Never

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

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

Printed Name______________________________________________________
Responsible Party Signature_________________________________________  Date____/____/_______