SMILES OF LOMBARD

ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

DATE: ____

NAME: ____

I. SUBJECTIVE COMPLAINTS AND CONCERNS

A. What are the patient's or parents' main concerns regarding the jaw and teeth?

	Mild	Moderate	Severe
1. Facial Pain	☐	☐	☐
2. Gum Disease/Recession	☐	☐	☐
3. Gum Problems	☐	☐	☐
4. Headaches	☐	☐	☐
5. Jaw Dysfunction	☐	☐	☐
6. Jaw Joint Sounds	☐	☐	☐
7. Jaw Pain	☐	☐	☐
8. Neck Pain	☐	☐	☐
9. Ringing or "Stuffy" Ears	☐	☐	☐

- ☐ Bad Bite
- ☐ "Buck" Teeth / Overjet
- ☐ Crowding of Upper Teeth
- ☐ Crowding of Lower Teeth
- ☐ Crowding of Upper and Lower Teeth
- ☐ Crossbite
- ☐ Dentist Recommended Seeing an Orthodontist
- ☐ Grinding Teeth
- ☐ Gummy Smile
- ☐ Impacted Tooth / Teeth
- ☐ Improper Tooth Position
- ☐ Irregular Shaped Tooth / Teeth
- ☐ Missing Tooth / Teeth
- ☐ Mouth Too Small
- ☐ Open Bite
- ☐ Prominent Low Jaw (too "strong")
- ☐ Protrusion of Teeth
- ☐ Recessive Lower Jaw (too "weak")
- ☐ Rotations
- ☐ Small Teeth
- ☐ Spaces
- ☐ Thumb / Finger Habit
- ☐ Underbite
- ☐ OTHER ______________________________

B. Family members with similar problems:

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ OTHER ______________________________

II. MEDICAL DENTAL HISTORY

A. Present Health

	Good	Fair	Poor
1. Physical	☐	☐	☐
2. Emotional	☐	☐	☐
3. Under Stress	☐	☐	☐

	Yes	No
B. Has the patient reached puberty?	☐	☐

C. Has the patient ever had any of the following conditions?

- ☐ Allergies
- ☐ AIDS / ARC / HIV (Circle)
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Disease
- ☐ Bone Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emotional Problems
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Female Problems
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Hearing Disorders
- ☐ Heart Disease / Surgery
- ☐ Hepatitis
- ☐ Herpes / Fever Blisters
- ☐ High Blood Pressure / Low Blood Pressure (Circle)
- ☐ Hospitalized for Any Reason
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Ringing of Ears
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Disturbance
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Trauma (to face, teeth, jaws or head)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ ______________________________

D. **MEDICATIONS** *(Current medications taken by patient):*

- ☐ Antibiotics
- ☐ Birth Control Pills
- ☐ Diet Pills (Diuretics)
- ☐ Heart Pills (Digitalis, etc.)
- ☐ Insulin
- ☐ Muscle Relaxants (Valium, etc.)
- ☐ Pain Pills (Demerol, Codeine, etc.)
- ☐ Sleeping Pills
- ☐ Tranquilizers (Elavil, Valium, etc.)
- ☐ Vitamins
- ☐ OTHER ______________________________________

E. ALLERGIES TO MEDICATIONS/FOOD *(The patient demonstrates an allergic response to):*

- ☐ Antibiotics (specifically) _________________________
- ☐ Aspirin
- ☐ Codeine
- ☐ Dairy Products
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Food Dyes
- ☐ Jewelry / Metals
- ☐ Latex
- ☐ Pain Pills (specifically) __________________________
- ☐ Wheat
- ☐ OTHER ______________________________________

F. OTHER PERTINENT INFORMATION *(Has the patient ever had a history of the following?):*

	Occasionally	Frequently
1. Other Habits	☐	☐
2. Colds	☐	☐
3. Difficulty Chewing	☐	☐
4. Difficulty Swallowing	☐	☐
5. Finger Sucking	☐	☐
6. Grinding Teeth	☐	☐
7. Headaches	☐	☐
8. Lip Biting	☐	☐
9. Mouth Breathing	☐	☐
10. Pain in Jaw Joint	☐	☐
11. Smoking	☐	☐
12. Snoring	☐	☐
13. Sore Teeth	☐	☐
14. Sore Throats	☐	☐
15. Speech Problems	☐	☐
16. Thumb Sucking	☐	☐
17. Tongue Thrusting	☐	☐
18. Tonsillitis	☐	☐
19. Other Habits	☐	☐
20. OTHER____________________	☐	☐

III. PATIENTS OR PARENTS ATTITUDE TOWARD TEETH CARE AND ORTHODONTIC TREATMENT

A. Regular dental checkups:

- ☐ Twice a year
- ☐ Once a year
- ☐ Only if necessary
- ☐ Never

B. Patient's interest in orthodontic treatment:

- ☐ Eager for treatment
- ☐ Willing if necessary
- ☐ Dreading but agrees
- ☐ Unwilling

C. Orthodontic consultation was prompted by:

- ☐ Patient (Name) ________________________________
- ☐ Dentist (Name) ________________________________
- ☐ Spouse
- ☐ Mother / Father (Circle)
- ☐ Brother / Sister (Circle)
- ☐ Other relative (Name) ___________________________
- ☐ Friend (Name) _________________________________
- ☐ OTHER _______________________________________

D. Has the patient ever had any unusual dental experience?

- ☐ No
- ☐ Yes If yes, please explain: ____________________ ______________________________________

E. Are there any medical, dental, surgical or psychological problems not covered above?

- ☐ No
- ☐ Yes If yes, please explain: ____________________ ______________________________________

F. Has the patient ever had a previous orthodontic consultation/treatment?

- ☐ No
- ☐ Yes If yes, Name of Doctor: ___________________

G. HEALTH PROFESSIONAL(S) *(Current or have seen previously)*

Doctor Name: ______________________________________
Reason(s) for treatment: ______________________________

Doctor Name: ______________________________________
Reason(s) for treatment: ______________________________

Doctor Name: ______________________________________
Reason(s) for treatment: ______________________________

H. Why are you seeking this consultation?

- ☐ To improve dental appearance
- ☐ To improve facial appearance
- ☐ To improve general appearance
- ☐ To improve longevity of teeth
- ☐ To improve self-esteem
- ☐ To reduce facial pain
- ☐ To reduce headaches/neckaches
- ☐ OTHER _______________________________________

Comments:

____
____
____
____

To the best of my knowledge, all the preceding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that are not reported above, I will inform the doctor at my next visit.

____
Patient/Responsible Party's Signature Date

____
Orthodontist/General Dentist's Signature Date

Date	Comments	

PROFILE
115 convax
116 concave
117 straight

MANDIBLE
118 mesognathic
119 retrognathic
120 prognathic

SYMMETRY
000 symmetrical
039 mandibles to RT
039 mandibles to LT
other ________

LIPS AT REST
058 together
059 apart
060 trapped

FACIAL HEIGHT
121 normal
122 short
123 long

DENTAL LEVEL
000 primary
000 mixed
000 permanent

TEETH PRESENT:

TEETH MISSING:

MOLAR CLASS
001 Class I
002 Class II div 1 RL
003 Class II div 2 RL
004 Class III

CROWDING
007 none upper
008 none lower
015 upper sl mod sev
016 lower sl mod sev

SPACING
005 upper
019 diasiama
005 lower

MAX MIDLINE
000 normal
040 to RT
041 to LT

SUPERNUM:

MAND MIDLINE
000 normal
042 to RT
043 to LT

OVERBITE
025 mod 25-75%
022 deep 75-100%
021 100% +
024 openbite
027 edge-edge

OVERJET
036 mod 1-3 mm
037 excess 4-6 mm
038 severe 7+
039 end-end

CROSSBITE
025 anterior

028 posterior

029 max buccal

ENAMEL DEFECTS
096 decalcifications
097 defects
098 attrition
379 abiraction

TMJ SYMPTOMS
051 none R,L
380 negload test
052 click/pop R, L
opening, closing,
lateral
055 crepitus R, L
056 condylar pain R, L
057 muscle pain

MANDIBULAR MOVEMENT
051 no deviation
053 opening deviation R, L
054 closing deviation R, L

RANGE OF OPENING
110 normal _____ mm
111 limited _____ mm

PERIO
084 healthy
085 gingivitis
087 recession
086 periodontis

COMMENTS: ____