active orthodontics

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# Orthodontic and Medical Questionnaire

**(Please tick or circle)**

Patient's Name: _____

General Dentist's Name: _____ Approx. month of last visit: _____

Has patient previously had an Orthodontic consultation? **YES / NO**

Has any Orthodontic appliance (brace/plate) been worn previously? **YES / NO**

Who suggested an Orthodontic consultation? **Parents / Dentist / Patient**

What is the main reason for seeking an Orthodontic consultation? _____

_____

Any other member of the family, or close relative, who has been treated in this practice? **YES / NO**

Age of eruption of teeth: Average: _____ Very Late: _____ Very Early: _____

General Health: _____

Are tonsils and adenoids present? **YES / NO**

Has the patient suffered from rheumatic fever, hepatitis (A, B, or C), convulsions, diabetes, tuberculosis or repeated headaches? **YES / NO**

Has the patient any tooth grinding habits? **YES / NO**

Has the patient had any accidents or operations involving the mouth and face? **YES / NO**

Please describe if "YES" _____

_____

Any thumb or finger sucking now? **YES / NO** Or previously? **YES / NO**

Any hay fever, asthma or allergies? **YES / NO** Allergy to Penicillin? **YES / NO**

Any difficulty in breathing through the nose? (awake and /or asleep) **YES / NO**

Any clicking or pain on opening or closing the mouth or yawning? **YES / NO**

Did your Dentist give you a letter or X-rays / disc to bring with you?

If they did, please hand it to the receptionist before the patient sees the Orthodontist.

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