"Embrace Your Future"

Patient Questionnaire

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodontic treatment. All information will be treated with complete confidentiality.

Patient Name _____

Date of Birth _____

General Medical Practitioner_____ **Tel No.** _____

How did you hear about us?_____

DENTAL HISTORY

Name of Dentist:_____ Location of Dentist:_____

Have Orthodontic appliances been worn previously? No ☐ Yes ☐

If yes, details_____

DENTAL TRAUMA

Have any accidents occurred that caused any of the following:

Tooth loss	☐	Chipping of any teeth	☐
Facial fractures	☐	Discolouration of any teeth	☐
Disturbance to jaw joints	☐		

ORTHODONTIC CONCERNS

Irregular teeth	☐	Inability to chew effectively	☐
Speech defect	☐	Missing teeth	☐
Pain in the face or joints	☐	Facial appearance	☐

Does the patient clench/grind his/her teeth? No ☐ Yes ☐ When _____
Does the patient have a nail biting habit? No ☐ Yes ☐
Does the patient suck thumb or fingers? No ☐ Yes ☐
If stopped, at what age? _____

Has the patient ever experienced:

Jaw/joint pain?	No ☐ Yes ☐	Jaw/joint locking?	No ☐ Yes ☐
Jaw/joint grating noises?	No ☐ Yes ☐	Jaw/joint clicking?	No ☐ Yes ☐
Jaw/joint popping?	No ☐ Yes ☐	Ringing in ears?	No ☐ Yes ☐

Has any other member of the family attended our surgery? No ☐ Yes ☐

Name of family member: _____

MEDICAL HISTORY

Has the patient experienced any health problems?
No ☐ Yes ☐ Explain _____

Mehta Orthodontics

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Has there been any major change in patient's health recently?
No ☐ Yes ☐ Explain _____

Does the patient snore?
No ☐ Yes ☐ Unsure ☐ _____

Has anyone noticed if the patient stops breathing during sleep?
No ☐ Yes ☐ If yes, how often_____

Is the patient currently taking medications?
No ☐ Yes ☐ Explain _____

Has the patient ever been hospitalised?
No ☐ Yes ☐ Explain _____

Have the patient's tonsils/adenoids been removed?
No ☐ Yes ☐ Explain_____

Does the patient have any physical or mental impairments?
No ☐ Yes ☐ Explain_____

Has or is the patient currently undergoing speech therapy?
No ☐ Yes ☐ Explain_____

Does the patient have any allergies?
No ☐ Yes ☐ Explain_____

Please tick if the patient has a history of any of the following conditions:

☐ Heart Murmur	☐ Haemophilia	☐ Tonsillitis
☐ Heart Surgery	☐ Blood Disease	☐ Hives/Rash
☐ Rheumatic Fever	☐ Arthritis	☐ Bone Disorders
☐ Diabetes	☐ Nervous/Anxious	☐ Kidney Disease
☐ Tuberculosis	☐ Hayfever	☐ Epilepsy
☐ Endocrine Disorders	☐ Thyroid Problems	☐ Hepatitis (A)
☐ Fainting Episodes	☐ Herpes (Fever Blisters)	☐ Hepatitis (B)
☐ Growth Disorder	☐ Allergies	☐ Hepatitis (C)
☐ Liver Disease	☐ HIV	☐ AIDS
☐ Heart Diseases	☐ Cancer	☐ Drug Addiction
☐ Mitral Valve Prolapse	☐ Developmental Disorders	☐ Asthma
☐ Frequent Headaches	☐ Mouth Breather	☐ Prolonged Bleeding

I consent to my Orthodontic records being used for dental education and training purposes:
No ☐ Yes ☐

I certify that the above medical history is accurate at this time. If there are future changes, I will inform the office.

Signature _____ **Date**_____

Patient Name _____

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