Orthodontic Health Information

Name_____ Age_____Birthday_____

Height_____Weight_____Recent gain_____Lbs. Recent loss_____Lbs.

History

Birth
- ☐ Adopted
- ☐ Difficult Labor
- ☐ Forceps
- ☐ Cesarean Section
- ☐ Nursed (how long)_____
- ☐ Bottle fed

Heredity

Have any other members of the family
(including grandparents) had jaw or similar problems?
Please explain:

_____

_____

Previous orthodontic treatment
Patient or others in family_____yes, _____no. Who? _____
What do you consider the main benefits of orthodontic correction?
_____Cosmetic, _____Functional, _____Psychological/Emotional. Other_____
Have you had: _____Previous dental treatment, _____Regular dental checkups, _____X-rays

Injuries and Operations

Injury to the jaw	_____	Excessively large bite or yawn	_____
Injury to the neck	_____	Irregular or raised dental filling	_____
Injury to the head	_____	Dental surgery	_____
Injury to the back	_____	Excessive opening of mouth	_____
Severe emotional upset	_____	Trauma to the jaw or head	_____
Whiplash injury	_____	Cervical traction	_____
Head or neck surgery	_____	Jaw or nose broken	_____

General Health: Robust_____ Average_____ Frail_____

- ☐ headaches
- ☐ frequent colds
- ☐ sinusitis
- ☐ allergy (hayfever)
- ☐ tendency to faint
- ☐ nervousness
- ☐ sight problem
- ☐ hearing or ear problem
- ☐ under psychological guidance
- ☐ tonsils in ( ) enlarged
- ☐ tonsils out
- ☐ asthma
- ☐ food allergies _____
- ☐ digestive upsets
- ☐ food-junkie
- ☐ drinks lots of milk

Appetite ☐ good ☐ fair ☐ poor

- ☐ adenoids in
- ☐ adenoids out
- ☐ muscle twitch
- ☐ mouth breather. When?_____
- ☐ neck or back aches
- ☐ onset of puberty

Habits

- ☐ thumb or finger sucking
- ☐ nail biting
- ☐ lip/tongue/cheek sucking, thrusting or biting
- ☐ pencil biting
- ☐ chew on one side or the other
- ☐ musical instrument _____
- ☐ walk erect ☐ sit and stand up straight

Sleep on right☐ left☐ chin☐ back☐
Lean on right☐ left☐ chin☐ back☐

- ☐ difficulty in swallowing or chewing: open mouth chewing, gulping, burping, hiccups, stomachaches
- ☐ clicking or pain when opening or closing mouth
- ☐ tooth clenching, night grinding
- ☐ chew gum
- ☐ poor speech habits, inappropriate speech sounds
- ☐ difficulty in swallowing pills
- ☐ night symptoms: snoring, drooling, grinding, apnea

Hobbies, interests _____

Date_____ Signature_____