CONFIDENTIAL

Shoreline Orthodontics ~ Dr. Paul J. Helpard Inc.
Certified Specialist in Orthodontics

ORTHODONTIC QUESTIONNAIRE FORM ~ ADULT

Patient's Last Name:	First Name:	Preferred Name:	DOB: (mm-dd-yy):
Mailing Address:			
Home Phone:	Business Phone:		
Cell Numbers: Self:	Spouse:	Other:	
Email Address:			
Spouse/Partner Name:		Person To Contact in Emergency:	
Whom may we thank for recommending our clinic?			
Family Members in Practice:			

DENTAL HISTORY

PERSONAL HISTORY

Family Dentist:	How long have you been a patient? months years
How would you rate the condition of your mouth? Excellent Good Fair Poor	
Date of most recent dental exam:	Date of most recent treatment:
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely	
What is your immediate concern?	
Are you fearful of dental treatment? Yes No	

For the following questions, answer **YES, NO,** or **DON'T KNOW (D/K)**

Question			
Have you had an unfavourable dental experience?	Y	N	D/K
Have you ever had an orthodontic consultation or your bite adjusted?	Y	N	D/K
Have you had any teeth removed?	Y	N	D/K

SMILE CHARACTERISTICS

Question			
Is there anything about the appearance of your teeth that you would like to change?	Y	N	D/K
Are you self conscious about your teeth?	Y	N	D/K

BITE AND JAW JOINT

Question			
Do you / would you have any problems chewing gum?	Y	N	D/K
Do you / would you have any problems chewing hard foods?	Y	N	D/K
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	Y	N	D/K
Are your teeth crowding or developing spaces?	Y	N	D/K
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	Y	N	D/K
Do you have any problems with sleep or wake up with an awareness of your teeth?	Y	N	D/K
Do you have any problems with your jaw joint(s)? (pain, sounds, limited opening, locking, popping?	Y	N	D/K
Do you have tension headaches or sore teeth?	Y	N	D/K
Do you wear or have you ever worn a bite appliance?	Y	N	D/K

GUM AND TOOTH STRUCTURE

Question			
Do you have any missing teeth?	Y	N	D/K
Are any teeth sensitive to hot, cold, biting or sweets?	Y	N	D/K
Have you ever been diagnosed or treated for periodontal (gum) disease?	Y	N	D/K
Have you ever experienced gum recession?	Y	N	D/K
Are your teeth becoming loose?	Y	N	D/K

HABITS

Question			
Do you clench (squeeze) or grind your teeth?	Y	N	D/K
Do you bite your lips or cheeks frequently?	Y	N	D/K
Do you have difficulty breathing through your nose?	Y	N	D/K
Do you or have you had a thumb or digit sucking habit?	Y	N	D/K
Are you aware of any tongue posture habits (tongue resting between or against the teeth)?	Y	N	D/K

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MEDICAL INFORMATION

Physician's Name:				
Most recent physical exam:				
What is your estimate of your general health?	Excellent	Good	Fair	Poor

DO YOU HAVE OR HAVE YOU EVER HAD: For the following questions, answer **YES, NO,** or **DON'T KNOW (D/K)**

Hospitalization for illness or injury	Y	N	D/K	Osteoporosis/osteopenia (ie taking bisphosphonates)	Y	N	D/K
An allergic reaction to:	Y	N	D/K	Arthritis	Y	N	D/K
Aspirin, ibuprofen, acetaminophen	Y	N	D/K	Contact lenses	Y	N	D/K
Penicillin	Y	N	D/K	Head or neck injuries	Y	N	D/K
Erythromycin	Y	N	D/K	Epilepsy, convulsions (seizures)	Y	N	D/K
Tetracycline	Y	N	D/K	Viral infections and cold sores	Y	N	D/K
Codeine	Y	N	D/K	Any lumps or swelling in the mouth	Y	N	D/K
Local anaesthetic	Y	N	D/K	Hives, skin rash, hay fever	Y	N	D/K
Fluoride	Y	N	D/K	Hepatitis (type)	Y	N	D/K
Metals (gold, stainless steel)	Y	N	D/K	HIV/AIDS	Y	N	D/K
Latex	Y	N	D/K	Tumour, abnormal growth	Y	N	D/K
Any other medications	Y	N	D/K	Radiation therapy	Y	N	D/K
Heart problems	Y	N	D/K	Chemotherapy	Y	N	D/K
Heart murmur	Y	N	D/K	Antidepressant medication	Y	N	D/K
Rheumatic fever	Y	N	D/K	Birth defects	Y	N	D/K
Scarlet fever	Y	N	D/K	Syndrome	Y	N	D/K
High blood pressure	Y	N	D/K	ADHD, ADD	Y	N	D/K
Low blood pressure	Y	N	D/K	FAS	Y	N	D/K
A stroke	Y	N	D/K	Autism spectrum disorder	Y	N	D/K
Artificial prosthesis (ie heart valve or joints)	Y	N	D/K	**ARE YOU:**	Y	N	D/K
Anaemia or other blood disorder	Y	N	D/K	Presently being treated for any other illness	Y	N	D/K
Prolonged bleeding due to a slight cut	Y	N	D/K	Aware of a change in your general health	Y	N	D/K
Tuberculosis	Y	N	D/K	Subject to frequent headaches	Y	N	D/K
Asthma	Y	N	D/K	A smoker or smoked previously	Y	N	D/K
Breathing or sleep problems (ie snoring, sinus, mouth breathing)	Y	N	D/K	FEMALE - taking birth control pills	Y	N	D/K
Kidney disease	Y	N	D/K	FEMALE – pregnant	Y	N	D/K
Thyroid or parathyroid disease	Y	N	D/K	Any other condition, disease or problem not listed we should know about:			
Hormone deficiency	Y	N	D/K				
Diabetes	Y	N	D/K	Describe any other current medical treatment, impending surgery, or other treatments that may possibly affect your dental treatment:			
Digestive disorder (ie gastric reflux)	Y	N	D/K				

List all medications, supplements and/or vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's signature: Date:

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