PRE-ORTHO QUESTIONNAIRE

Patient's Name: ________________________________

Date: ________________________________

Please tell us why you came for evaluation and possible treatment.
Ask your child to answer these questions or fill out this form for him/her.

Check all that apply:

- ❑ My teeth are crowded.
- ❑ I want to fix my overbite.
- ❑ I don't like my smile.
- ❑ I don't like the appearance of my teeth.
- ❑ I want my teeth to function better.
- ❑ I don't like being teased about my teeth at school.
- ❑ I have an airway problem. *(snoring)*
- ❑ My dentist found the problem.
- ❑ I/we do not see a problem.
- ❑ If there is any other reason, please mention it here: ________________________________

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Check YES or NO:

❑ YES ❑ NO Are there any habit(s) you are concerned about? *If YES, please check which ones below:*
❑ Thumb Sucking ❑ Tongue Habit ❑ Mouth Breathing

❑ YES ❑ NO Have you had your tonsils or adenoids removed? *If YES, at what age?*______________

❑ YES ❑ NO Do you have a tendency to get colds?

❑ YES ❑ NO Do you get sore throats?

❑ YES ❑ NO Do you get ear infections?

❑ YES ❑ NO Have you ever had tubes in your ears? *If YES, at what age?* ______________

❑ YES ❑ NO Have you ever sucked your thumb or finger? *If YES, until what age?*______________

❑ YES ❑ NO Do you have any speech problems?

❑ YES ❑ NO Do you breathe through your mouth? *If YES, when:* ❑ *Day* ❑ *Night*

❑ YES ❑ NO Do you play any musical *(mouth)* insturments?

❑ YES ❑ NO Have you consulted an orthodontist or another dentist regarding the orthodontic or TMJ problem?

❑ YES ❑ NO Has either of your parents ever had ortho treatment?

________________________________ ________________
Signature of Patient (Parent or Guardian if patient is a minor) *Date*