

PRE-CONSULTATION QUESTIONNAIRE
PLEASE CHECK THE APPROPRIATE SQUARE

Name _____
 Age _____ yr. _____ m.
 Date _____
 Phone _____

| | Yes | No | Not Sure |
|---|--|--|--|
| 1. Is there a history in your family of irregular teeth? protruding teeth? congenitally missing teeth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has any (other) member of your family had orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is your child's orthodontic problem obvious to you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is your child becoming self conscious because of his or her teeth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your child have frequent indigestion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Did your child suck his or her thumb during infancy? After age 3? After age 7? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 7. Does your child play any wind instruments? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has your child had any severe accidents involving his or her teeth? jaws? lips? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 9. Does your child have frequent sore throats? colds? asthma? hay fever? other allergies? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 10. Do you often notice that your child is breathing through his mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has your child had his/her tonsils and adenoids removed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has your child had any baby teeth extracted because of decay? to make room for permanent teeth? because they would not fall out normally? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 13. If baby teeth were extracted were space maintainers used to prevent closing of the extraction space? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has your child had any previous orthodontic treatment or consultation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Is your child in good general health? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has your child ever had any of the following? heart trouble <input type="checkbox"/> rheumatic fever <input type="checkbox"/> diabetes <input type="checkbox"/> epilepsy <input type="checkbox"/> thyroid disease <input type="checkbox"/> lung disease <input type="checkbox"/> blood disorders <input type="checkbox"/> abnormal blood pressure <input type="checkbox"/> anaemia <input type="checkbox"/> kidney disease <input type="checkbox"/> sinusitis <input type="checkbox"/> muscular dystrophy <input type="checkbox"/> hepatitis, jaundice or liver disease <input type="checkbox"/> speech problems <input type="checkbox"/> malignant hyperthermia <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Is your child taking any medicines or drugs at the present time? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has your child experienced any unusual reaction of any of the following drugs? penicillin <input type="checkbox"/> aspirin <input type="checkbox"/> codeine <input type="checkbox"/> or other medicine <input type="checkbox"/> _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Is there anything that the orthodontist should know regarding your child's medical or dental history that has not been mentioned? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |