CONSULTATION QUESTIONNAIRE

DISCOVER ORTHODONTICS

CREATING Beautiful SMILES

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WWW.DISCOVERORTHO.CA

PATIENT (PLEASE PRINT) Date_____

Name_____Address_____

City_____Postal Code_____Home Tel_____Cell #_____Emergency #_____

Age_____Birthdate_____Email_____Sex Male ☐ Female ☐

Dentist_____Dentist Tel_____Physician_____

RESPONSIBLE PARTY

Name_____ Birthdate_____Relationship to patient_____

Mailing Address_____

Employer_____Bus. #_____

Who may we thank for referring you to our office?

Dentist ☐ Specialist ☐ Patient ☐ Other ☐

Name_____

Yes	No	Unsure	Medial History (continued)
			Is the patient in good general health? When was the last medical check-up or visit to a physician? What was the reason for this medial visit?_____
			Has there been a change in general health in the past year?
			Is there currently treatment ongoing for any medical condition or has treatment been provided within the last year? Please provide reason:_____
			Is there a history of having been hospitalized for any serious condition or operation? Please specify:_____
			Is there currently a need for medication or non-prescription drugs of any kind? If yes, please specify:_____
			Is there a history of any allergies? (i.e. metals, environmental, etc.)_____
			Has there ever been a history of a peculiar or adverse reaction to any medication or injection? (i.e. penicillin, aspirin, or local anesthetics “dental freezing”)_____
			Is there a tendency to breathe through the mouth?
			Have the tonsils and/or adenoids ever been removed?
			Is there a history of heart or blood pressure problems?
			Is there a history of prosthetic cardiac valve, previous infective endocarditis, congenital heart disease, cardiac transplantation or cardiac valvulopathy?
			Has there ever been a history of rheumatic fever?
			Has there ever been a history of jaundice, hepatitis or liver disease or a knowledge of contact with a person with any of these conditions?
			Has the patient ever been advised not to give blood?

Yes	No	Unsure	Medial History (continued)
			Is there a history of conditions that could affect the immune system? (i.e. AIDS, HIV Positive, Leukemia, etc.)
			Is there a tendency to bruise easily or bleed for a prolonged period of time?
			Is there a history of any of the following? (*Please tick only those that apply)* ___Chest pain ___heart attack ___stroke ___bronchitis ___emphysema ___asthma___arthritis ___diabetes ___prosthetic joint ___stomach ulcers ___drug/alcohol dependency ___kidney disease ___epilepsy ___TB
			Does the patient currently smoke or chew tobacco?
			For women only - Are you pregnant? If so, what is the expected delivery date?_____
Yes	**No**	**Unsure**	**Dental History**
			When was the last dental visit?_____
			When were the last dental x-rays taken?_____
			Has the patient been seeing a dentist regularly?
			Do any of the teeth currently ache?
			Has the patient ever been advised to take antibiotics before a dental appointment?
			Is the patient receiving any care by any other dental specialist?
			Please list anything else not mentioned above regarding the patients past dental history: _____ _____
Yes	**No**	**Unsure**	**Orthodontic History**
			Is there a history in your family of irregular teeth?
			Is there a history in your family of congenitally missing teeth?
			Has any other family member had orthodontic treatment?
			Is the patient satisfied with the appearance of the teeth?
			Has there been a finger or thumb sucking habit - ongoing or in the past?
			Has the patient had any accidents involving the teeth, jaws or nose?
			Does the patient suffer from frequent headaches or ear aches?
			Has the patient had any teeth extracted by the dentist in the past?
			Has there been any previous orthodontic treatment?
			Has there been any previous orthodontic consultations?

As part of PIPEDA and the Regulated Health Professions Act, we are required to ask for permission to be able to correspond with other associated healthcare personnel (i.e. family dentist).

Permission Granted _____
(PARENT/GUARDIAN SIGNATURE)

To the best of my knowledge
the above information is correct: _____ _____
(SIGNATURE) (DATE)

Reviewed by treating orthodontist: _____ _____
(SIGNATURE) (DATE)