Child Medical and Dental History

Medical History:

Child's Name: ______________________________
Name of Child's Physician: ______________________ Phone #______________________
Location (city): ______________________ Date of last Visit: ______________________

Current physical health is: Good Fair Poor
Is your child currently under the care of a doctor? Y N Reason: ______________

____

Is your child taking any prescription medications? Y N
Please list: ____

Has your child ever had any of the following diseases or medical problems? (Please circle Y or N)

Y N Heart murmur
Y N Rheumatic fever
Y N Mitral valve prolapse
Y N Heart surgery/ Pacemaker
Y N Congenital heart defect
Y N Heart attack
Y N Artificial heart valves
Y N Fever blister
Y N Ulcer/Colitis
Y N Sinus problems
Y N Abnormal bleeding
Y N Kidney problems
Y N Liver problems
Y N Facial pain
Y N Drug/Alcohol abuse
Y N Glaucoma
Y N Injury to head or neck
Y N Major surgeries
Y N Artificial joints
Y N Arthritis
Y N Pituitary problems

Y N HIV/AIDS
Y N Cancer, radiation treatment, chemotherapy
Y N Allergies/Hay fever
Y N Diabetes
Y N Hemophilia
Y N Hepatitis
Y N Shingles
Y N Acid reflux
Y N Emphysema
Y N Convulsions/Epilepsy
Y N Tuberculosis
Y N Tobacco use
Y N Sev/Freq. Headaches
Y N Hi/Lo blood pressure
Y N Blood transfusion
Y N Difficulty breathing/ Asthma
Y N Unusual growth pattern
Y N Thyroid problems
Y N Eye, ear, nose or throat condition
Y N Mental health disturbance or depression

If yes to any of the above questions, please explain: ______________________________

____

Any other medical condition that we should know about? Y N ______________________

Is your child allergic to any medications? Y N
Please list: ____
Is your child allergic to (please circle Y or N)

Y N Latex
Y N Nickel or other metals
Y N Dental anesthetics
Y N Plastics or acrylics
Y N Food______________
Y N Other______________

Over☞

Dental History:

Dentist's Name: ______________________________
Location (city): ______________________________
Date of last visit: ______________________________

What is the main concern that you would like orthodontics to accomplish? ______________________________

Current dental health is: Good Fair Poor
Does your child brush his/her teeth daily? Y N

Has your child ever had a serious problem associated with dental work? Y N
If yes, please explain: ______________________________

Has a doctor told you that your child needs to take antibiotics or any other medications before dental work? Y N
If yes, please explain: ______________________________

Has your child ever had any pain, tenderness, or locking in the jaw joint, or jaw muscles (TMJ/TMD)? Y N

Has your child ever had any of the following?

Y N Gum disease
Y N Missing or extra permanent teeth
Y N Sores, lumps, or irritated areas in mouth
Y N Previous orthodontic treatment
Y N Recurrent pain in mouth
Y N Speech problems
Y N Grinding/clenching of teeth
Y N Chewing on objects
Y N Recurrent tooth pain
Y N Unfinished dental treatment
Y N Mouth breathing
Y N Lip sucking or biting
Y N Thumb/ finger sucking
Y N Other:

Growth information for patients under 18 years of age:
(This information will help us determine jaw growth potential)

Father's Height ________ Mother's Height __________ Patient's Height _________
Patient resembles: Mother Father Neither parent Adopted
GIRLS: Has she started menstruation? Y N When? ______________________
BOYS: Has his voice changed? Y N When? ______________________

Names and ages of patient's siblings: ______________________________
Have any siblings had orthodontic treatment? Y N

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

____
Signature Date