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CHILD DENTAL AND MEDICAL HISTORY

Date ____________________

Name ______________________________ Nickname ____________________
(first) (middle) (last)

Date of Birth ____________________ Age __________ Sex: M ______ F ______

Address ____________________ City ____________________ Zip __________

Telephone (Home) ______________ Work Phone: Mom ______________ Work Phone: Dad ______________

Family dentist ______________ City ______________ Phone ______________

Family physician ______________ City ______________ Phone ______________

School ______________ City ______________ Grade ______________

Sports/Hobbies etc. ____

FAMILY HISTORY

Parents: Married _____ Separated _____ Divorced _____ Child Lives with ____________________

Father's Name ____________________ Social Security # ______________ Birthdate ______________

Address (if different from above) ____________________ Telephone ______________

Employer Name and Address ____

Stepfather (if applicable) ____________________ Social Security # ______________ Birthdate ______________

Mother's Name ____________________ Social Security # ______________ Birthdate ______________

Address (if different from above) ____________________ Telephone ______________

Employer Name and Address ____

Stepmother (if applicable) ____________________ Social Security # ______________ Birthdate ______________

Names and ages of brothers and sisters ____

Other family members with similar dental conditions (names and ages) ____________________

____

Other family members with orthodontic treatment (including parents) ____________________

Have you had any other experiences with or seen another orthodontist? No _____ Yes _____ Name ______________

MEDICAL HISTORY

General Health: Good __________ Fair __________ Poor __________ Height: ______________ Weight ______________

Birth defects ____

Presently under medical care for ____

Drugs or medications being taken now, including acne medications (drug and dose) ____________________

Allergic to what medication ____

Please check yes or no to the following and date:

	Yes	No	Year
Adopted Child	☐	☐	______
Adenoids (removed)	☐	☐	______
Allergies	☐	☐	______
Blood/Bleeding Problems	☐	☐	______
Bone disorder	☐	☐	______
Diabetes	☐	☐	______
Ear/nose infections	☐	☐	______
Emotional	☐	☐	______
Endocrine disorder	☐	☐	______
Epilepsy	☐	☐	______
Fainting Spells	☐	☐	______
Glaucoma	☐	☐	______
Heart disorder murmur	☐	☐	______
Hepatitis	☐	☐	______
Hospitalized	☐	☐	______
Hyperactivity	☐	☐	______
Learning Disability	☐	☐	______
Liver disorder	☐	☐	______
Lung disorder	☐	☐	______
Rheumatic fever Scoliosis	☐	☐	______
Speech difficulty	☐	☐	______
Tonsils (removed)	☐	☐	______
Turners Syndrome	☐	☐	______
Venereal disease	☐	☐	______
Other ______________			

Please give any additional information or details where necessary ____________________

PLEASE COMPLETE REVERSE SIDE

MATURATION

Have you grown very much in the past year? Yes ________________ No ____________________ How many inches? ______________________

Female patients: Monthly Periods? Yes ________________ No ____________________ started at age __________________________________

Male Patients: Voice change? Yes ____________________ No ____________________Facial Hair? Yes __________________ No __________

Other indications of pubertal development ____

DENTAL HISTORY

Date of last dental check-up ____

Injury or trauma to the face or teeth ____

Brushing teeth: Several times per day__________________ once a day ______________________ rarely______________________________

Does the patient play a musical instrument? ____

Thumb sucking ____________________________________ discontinued at the age of____

Other habits: lip biting, nail biting specify____

Breathing: nose __________________ mouth __________________ difficulty at night __________________ snoring _____________________

Bruxism: (grinds teeth) Yes__________________ No ____________________ at night ________________ daytime____________________

Jaw point (TMJ problems) noise ______________ pain ____________ earaches/ringing __________________soreness & stiffness _____________
____

Speech: difficulty in pronunciation Yes ________________ No ____________________ Speech lessons Yes ______________ No __________

PATIENT TREATMENT ATTITUDE

Major reason for seeking treatment____

How did you become aware of the orthodontic problem? ____

Patient interest in treatment:

- ❑ patient wants treatment
- ❑ unwilling but agrees
- ❑ treatment if necessary
- ❑ uncooperative

Questionnaire completed by ____ relation to patient ____________________________________

How and when did you first hear about our office?____
____

Whom may we thank for referring you to our office? ____

Comments ____
____
____
____