CHILD PATIENT HISTORY FORM CONTINUED

CHILD'S MEDICAL HISTORY

Have you had / experienced any of the following:

Y N Mitral Valve Prolapse
Y N Heart Disease
Y N Cancer
Y N Diabetes
Y N Allergies
Y N Convulsions
Y N Glaucoma
Y N Epilepsy
Y N Emotional problems
Y N Psychological guidance
Y N Bleeding disorders
Y N Hepatitis or
Y N AIDS
Y N Latex/rubber sensitivity
Y N Headaches
Y N Heart Murmur
Y N Removal of Tonsils
Y N Removal of Adenoids
Y N Rheumatic Fever
Y N Extensive X-ray therapy

Is the patient under the care of a physician? Y N If yes, what for? ______________________________
Please list all medications the patient is currently taking? ______________________________
Does the patient require pre-medication before dental visits? Y N ______________________________
Has the patient been ill for more than 5 days in the last year? Y N ______________________________
Any overnight hospitalizations? Y N ______________________________
Has the patient ever had operations or injuries of the head or neck? Y N ______________________________
Are there any other medical problems not listed above? ______________________________

DENTAL HISTORY

Has the child had/experienced any of the following:

Y N Clicking/snapping of the jaw joint
Y N Removal of any permanent teeth
Y N Mouth Breathing (primarily)
Y N Speech problems / therapy
Y N Thumb sucking
Y N Finger sucking
Y N Lips / tongue sucking
Y N Clenching/grinding of teeth
Y N Bleeding gums
Y N Teasing due to appearance of teeth

Has the patient experienced a sudden increase in height? Y N

If the patient is male, has his voice changed? Y N

If the patient is female, has she started her monthly period? Y N

Is the patient aware of or concerned about his/her orthodontic problem? Y N ______________________________

Patient's attitude toward wearing orthodontic appliances: ☐ eagerness ☐ willingness ☐ complacency ☐ resignation ☐ antagonism

Expected patient cooperation: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who first noticed the need for orthodontic treatment? ☐ Parents ☐ Dentist ☐ Patient ☐ Other ______________

Are the parents interested in orthodontic treatment for: ☐ Appearance ☐ Better Bite ☐ Psychological ☐ Advice of Dentist

Has any member of the family had orthodontic treatment? Y N

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

Patient's interests: ______________________________

Dentist's Name: ______________________________

Date of last dental exam: ______________________________

What have you liked most about any dentist you have seen? ______________________________

What have you liked least about any dentist you have seen? ______________________________

Is there anything you would like to discuss with the Doctor in private? Y N

Authorization

I affirm that the information I have given is correct to the best of my knowledge. 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. I authorize the orthodontic staff to perform the necessary dental services my child may need.

Signature of parent or guardian ______________________________ Date ______________________