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CHILD HEALTH HISTORY

The information requested below is extremely important. Please complete it as accurately as possible so we can provide your child with the best possible orthodontic evaluation. Your answers are for office records only and completely confidential. For patients of children, please complete all of the information for your child. Thank you.

Date: _____

HEALTH HISTORY

1. Patient's name: _____ Social Security#:_____
2. Nickname or preferred name (if any): _____
3. Date of birth: _____ Place of birth: _____
4. Age of patient: ___years ___months Sex: ___Female___Male___ Height____ Weight_____
5. Is the patient adopted: ____Yes ____No Comments: _____

FAMILY

1. Please provide the following:

	Name	Sex	Date of Birth	Height	Weight
Father					
Mother					
Siblings (brothers & sisters)					

2. Parents are:____Married____Separated____Divorced____Widowed
3. Occupation/place of employment of father:_____Work Phone:_____
   Cell phone: _____ Email address: _____
4. Occupation/place of employment of mother:_____Work Phone:_____
   Cell phone: _____ Email address (es): _____
5. Home address: _____
   City, State, Zip code: _____
6. Home Telephone #: (_____) -_____ -_____

DENTAL

1. In your own words, please describe the orthodontic problem as you see it:
   _____
2. Has the patient had previous orthodontic examination or treatment? YES_____NO_____
   With whom? _____
3. Has anyone else in the family received orthodontic care? YES_____NO_____
   Where was the family member treated? _____
4. By whom were you directly referred? _____
5. Name of general dentist? _____
6. When did the patient last receive dental care and for what? _____
7. Have you been pleased with the patient's previous dental care? YES_____ NO____
   If no, please explain: _____
   How do you think the patient will react to orthodontic treatment?
   ▫ Excellent ▫ Good ▫ Fair ▫ Poor ▫ I don't know

8. How frequently does the patient brush their teeth? _____
9. Does the patient use dental floss? YES_____NO_____
10. Does the patient use fluoride supplements? YES_____NO_____
11. Have the patient's teeth ever been injured? YES_____NO_____
    What was the cause of the accident? _____
    How old was the patient? _____
    Which teeth were involved? _____
12. If the patient has any of the following habits, please check:
    ▫ Lip sucking ▫ Thumb or finger sucking ▫ Lip biting ▫ Mouth breathing
    ▫ Nail biting ▫ Tongue thrusting ▫ Grinding ▫ Snoring
13. Has the patient had any unfavorable experiences in a dental or medical office? YES_____NO_____
    If yes, please describe: _____
    _____
14. Rate the patient's concern for correction of orthodontic problem:
    ▫ Very concerned ▫ Concerned ▫ Indifferent ▫ Opposed ▫ I don't know
15. Rate the parent's concern for correction of orthodontic problem:
    ▫ Very concerned ▫ Concerned ▫ Indifferent ▫ Opposed ▫ I don't know

MEDICAL

1. Patient's physician? _____
2. Physician's address:_____ Telephone number: _____
3. Most recent physical exam: _____ Reason:_____
4. Were there any difficulties during the pregnancy, delivery, or first year of the patient's life? YES_____NO_____
    If yes, please explain: _____
    _____
5. Did the patient remain in the hospital longer than the mother? YES_____NO_____
6. Was the patient premature? YES_____NO_____
7. Has the patient ever been hospitalized since birth? YES_____NO_____
    If yes, what age(s) and reasoning: _____
    _____
8. Is the patient being treated by any other medical professional at this time? YES_____NO_____
    Whom? What condition? _____
    _____
    Is the patient taking any medication at this time? YES_____NO_____
    Check which kind? ▫ antibiotics ▫ anticoagulants ▫ tranquilizers ▫ cortisone
    ▫ anticonvulsants ▫ others: _____
9. Is there a past history of patient taking any of the above medications? YES_____NO_____
10. Does the patient have any history of allergies?
    If yes, to what? _____
    Describe the allergic reaction? _____
    Describe treatment used? _____
11. Has the patient had any unfavorable reactions to the following drugs? Please check:
    ▫ penicillin ▫ local anesthetic ▫ barbiturates ▫ codeine ▫ general anesthetic
    ▫ aspirin ▫ sulfa drugs ▫ metals ▫ latex ▫ acrylic ▫ other medications _____
    ▫ foods (specify) _____
12. If the patient has had any of the following diseases, please check each one and indicate approximate age:

▫ measles (regular)	AGE:_____	▫ whopping cough	AGE:_____
▫ chicken pox	AGE:_____	▫ broken bones	AGE:_____
▫ mumps	AGE:_____	▫ serious accidents	AGE:_____
▫ pneumonia	AGE:_____	▫ removal of tonsils & adenoids	AGE:_____
▫ scarlet fever	AGE:_____	▫ german or "3 days measles"	AGE:_____

13. If the patient has any history of the following, please check which one(s):
    - ▫ hearing difficulties _____
    - ▫ speech difficulties _____
    - ▫ emotional difficulties_____
    - ▫ fainting or dizziness_____
    - ▫ point visition_____
    - ▫ liver disease or heptatis _____
    - ▫ diabetes_____
    - ▫ birth defects_____
    - ▫ tuberculosis_____
    - ▫ asthma or wheezing_____
    - ▫ bone and joint problems_____
    - ▫ rheumatic fever_____
    - ▫ skin problems _____
    - ▫ epilepsy or seizures _____
    - ▫ cerebral palsy_____
    - ▫ disease(s) affecting normal growth_____
    - _____
    - ▫ HIV or AIDS_____
    - ▫ anemia_____
    - ▫ bleeding problems_____
    - ▫ heart problems_____
    - ▫ blood transfusions_____
    - ▫ sickle cell anemia_____
    - ▫ kidney disease_____
    - ▫ There is NO history of any of the above concerns
14. Is there a history of the following diseases or conditions in the patient's family? YES____NO____
    Please check which ones(s):
    - ▫ heart disease ▫ tuberculosis ▫ birth defects_____
    - ▫ diabetes ▫ cancer ▫ kidney disease
    - ▫ sickle cell anemia ▫ liver disease ▫ bleeding problems
    - ▫ hypertension ▫ congeniality missing teeth
15. Has the patient missed any days of school associated to an illness within the year? YES___NO___
16. Are patient's activities restricted due to health reasons? YES___NO____
17. Has the patient had any history of persistent and/or severe sore throats, tonsillitis or earaches? YES____NO___
18. Has there ever been any history of prolonged bleeding following tooth removal, surgery, cuts, etc? YES___NO____
19. **Female patients only**: At what age did the patient's menstruation (menarche) begin? _____

SOCIAL

1. Name of School:_____Grade:_____
2. Address:_____
3. Please check which one of the following best describes the patient:
    - ▫ advanced in the learning process
    - ▫ progressing normally in the learning process
    - ▫ a slow learner
4. Please check all the words which seem to best describe the patient:
    - ▫ calm ▫ highstrung ▫ spoiled ▫ active
    - ▫ cooperative ▫ moody ▫ suspicious ▫ fearful
    - ▫ defiant ▫ shy ▫ talkative ▫ compulsive
    - ▫ friendly ▫ sickly ▫ temper tantrums ▫ healthy
5. Does the patient have any pets, hobbies or special interests:
    Please list type of pet and hobbies? _____
    _____

I have read and understand all of the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of the above information. If there are any changes later to this history record or medical/dental status, I will inform the practice.

Signed:_____Date:_____
(Parent or Guardian)
Signed:_____Date:_____
(Dental Staff Member)