

Child Patient History Form

PLEASE COMPLETE BOTH SIDES

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_ Male/Female

In your own words, why are you seeking orthodontic treatment? What problems of the patients face, mouth, and teeth concern you? \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Patient's Interest \_\_\_\_\_ Hobbies \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

MEDICAL HISTORY - Please check any of the following conditions or problems patient has experienced:

- Anemia ..... Yes ( ) No ( ) Endocrine (Hormone) ... Yes ( ) No ( ) Hospitalizations ..... Yes ( ) No ( )
Asthma ..... Yes ( ) No ( ) Epilepsy ..... Yes ( ) No ( ) HIV + ..... Yes ( ) No ( )
Blood Transfusion ..... Yes ( ) No ( ) Excessive Bleeding ..... Yes ( ) No ( ) Hyperactive ..... Yes ( ) No ( )
Bone Fracture ..... Yes ( ) No ( ) Fainting or dizziness ..... Yes ( ) No ( ) Kidney problems ..... Yes ( ) No ( )
Contact Lenses ..... Yes ( ) No ( ) Headache ..... Yes ( ) No ( ) Learning problems ..... Yes ( ) No ( )
Convulsions/seizures .. Yes ( ) No ( ) Hepatitis ..... Yes ( ) No ( ) Liver problems ..... Yes ( ) No ( )
Diabetes ..... Yes ( ) No ( ) Hearing problems ..... Yes ( ) No ( ) Rheumatic fever ..... Yes ( ) No ( )
Emotional ..... Yes ( ) No ( ) Heart problems ..... Yes ( ) No ( ) Speech problems ..... Yes ( ) No ( )

List any other medical problems: \_\_\_\_\_

Is patient in good health? Yes ( ) No ( ) Are you taking Bisphosphates such as Fosamax or Boniva? Yes ( ) No ( )

Have tonsils and adenoids been removed? Yes ( ) No ( ) If so, what age? \_\_\_\_\_

List all medications you are currently taking, including prescription, over the counter, vitamins or herbal supplements: \_\_\_\_\_

Briefly give reasons: \_\_\_\_\_

List any allergies or drug sensitivity: \_\_\_\_\_

Allergy to Latex? Yes ( ) No ( ) Allergy to any metals, such as jewelry? Yes ( ) No ( ) \_\_\_\_\_

GROWTH INFORMATION

Has the patient reached puberty?

Girls - Has she started menstruation? Yes ( ) No ( ) Age started: \_\_\_\_\_

Boys - Has his voice changed? Yes ( ) No ( ) At what age: \_\_\_\_\_

Does patient's face resemble: Natural Father \_\_\_\_\_ Natural Mother \_\_\_\_\_ Both \_\_\_\_\_ Neither \_\_\_\_\_

DENTAL HISTORY

Do you consider patient's oral hygiene: Poor \_\_\_\_\_ Fair \_\_\_\_\_ Excellent \_\_\_\_\_

Has the patient ever sucked a thumb or finger? Until what age \_\_\_\_\_ Yes ( ) No ( )

Does patient clench or grind his/her teeth? ..... Yes ( ) No ( )

Does patient have any pain or clicking upon opening or closing the mouth? ..... Yes ( ) No ( )

Which side? Left \_\_\_\_\_ Right \_\_\_\_\_

Has the patient's jaw ever "locked" ..... Yes ( ) No ( )

Does the patient have any history of headaches or pain about the neck or head? ..... Yes ( ) No ( )

Does patient have painful gums? ..... Yes ( ) No ( )

Have there been any injuries to the face, mouth, or teeth? ..... Yes ( ) No ( )

If yes, explain \_\_\_\_\_

Have you been informed of any missing or extra permanent teeth: ..... Yes ( ) No ( )

Has an Orthodontist been previously consulted? ..... Yes ( ) No ( )

Has the patient previously received orthodontic treatment? ..... Yes ( ) No ( )

Does the patient see a Dentist for regular dental treatment? How often? \_\_\_\_\_ Yes ( ) No ( )

Does the PATIENT desire orthodontic treatment? ..... Yes ( ) No ( )

