



## DENTAL HISTORY

Any injuries to the face, mouth, or teeth? Yes No  
 \_\_\_\_\_

History of thumb or finger habit? Yes No  
 Until what age? \_\_\_\_\_

Does the patient have speech problems? Yes No  
 Describe \_\_\_\_\_

Is your child a mouth breather? Yes No  
 While awake? Yes No  
 While asleep? Yes No

Missing or extra permanent teeth? Yes No  
 \_\_\_\_\_

Have you previously consulted an orthodontist? Yes No

Previous orthodontic treatment? Yes No

Has either parent had orthodontic treatment? Yes No

Are antibiotics required prior to dental appts? Yes No

Has your child ever experienced pain/  
 discomfort in their jaw joint (TMJ/TMD)? Yes No

Grinding or clenching habit? Yes No  
 Chewing on objects? Yes No  
 Lip sucking/biting? Yes No  
 Nail biting? Yes No  
 Tongue thrust? Yes No

## EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near  
 that we should contact?  
 \_\_\_\_\_

Relation: \_\_\_\_\_

Hm #: \_\_\_\_\_ Wk#: \_\_\_\_\_

## MEDICAL HISTORY

Physician's name: \_\_\_\_\_ # \_\_\_\_\_

Is your child currently under the care of a physician? If so please  
 explain: \_\_\_\_\_

List any medications being taken and reason: \_\_\_\_\_  
 \_\_\_\_\_

List any drugs/materials that your child is allergic to:  
 \_\_\_\_\_

Has your child's tonsils and/or adenoids been removed? If yes, what  
 age \_\_\_\_\_

Has your child had any of the following medical problems/procedures?

Y N	Abnormal bleeding	Y N	Hepatitis
Y N	ADD/ADHD	Y N	Herpes/fever blisters
Y N	Alcohol/drug abuse	Y N	High blood pressure
Y N	Anemia	Y N	HIV+/AIDS
Y N	Arthritis	Y N	Hives
Y N	Artificial bones etc.	Y N	Prev. hospitalization
Y N	Asthma	Y N	Kidney/liver prob.
Y N	Blood transfusion	Y N	Low blood pressure
Y N	Bone disorder	Y N	Measles
Y N	Cancer/chemotherapy	Y N	Mononucleosis
Y N	Chicken pox	Y N	Nervous disorder
Y N	Colitis	Y N	Pneumonia
Y N	Diabetes	Y N	Psychiatric problems
Y N	Difficulty breathing	Y N	Prosthetics
Y N	Emphysema	Y N	Radiation
Y N	Endocrine problems	Y N	Rheumatic/scarlet fever
Y N	Epilepsy	Y N	Seizures
Y N	Fainting or dizziness	Y N	Shingles
Y N	Frequent headaches	Y N	Sickle cell
Y N	Glaucoma	Y N	Sinus problems
Y N	Handicap/disabilities	Y N	Skin rash
Y N	Hay fever	Y N	STD's
Y N	Hearing impairment	Y N	Stroke
Y N	Heart trouble	Y N	Thyroid problems
Y N	Hemophilia	Y N	Tuberculosis
		Y N	Ulcers

Other illness or operations: \_\_\_\_\_

Would you like to discuss anything with the Dr. in private? \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Doctor's comments:**  
 \_\_\_\_\_

## MEDICAL HISTORY UPDATE

1. Date: _____	Comments _____	Signature: _____
2. Date: _____	Comments _____	Signature: _____
3. Date: _____	Comments _____	Signature: _____