CERTIFIED SPECIALISTS
IN ORTHODONTICS

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CHILD MEDICAL HISTORY FORM UPDATED

PATIENT'S FULL NAME____ NAME PATIENT PREFERS__________________ DATE____________

BIRTHDATE: MONTH_____________ DAY________ YEAR_________ AGE______________________ SEX______________

ADDRESS________________________________ CITY______________ P. CODE____________ PHONE__________________

SCHOOL____ GRADE______________________________________

PARENT/GUARDIAN________________________________ RELATIONSHIP TO PATIENT______________________________

DENTIST____ PHYSICIAN___________________________________

PATIENT HEALTH HISTORY:

IS THE GENERAL HEALTH GOOD?______________ ANY MAJOR OR UNUSUAL ILLNESSES:_________________________

ANY ALLERGIC REACTIONS?__________________ TAKING ANY MEDICATION?__________________________________

HAS PATIENT SEEN A PHYSICIAN IN THE PAST SIX MONTHS?____

PLEASE CIRCLE IF PATIENT HAS/HAD ANY OF THE FOLLOWING:

HEART PROBLEMS	ASTHMA	FAINTING	HEPATITIS (LIVER DISEASE)
RHEUMATIC FEVER	TUBERCULOSIS	BLEEDING	KIDNEY DISEASE
DIABETES	CONVULSIONS	ALLERGIES	THYROID PROBLEMS
NERVOUS DISORDERS			

HAVE THE TONSILS BEEN REMOVED? ____________________ AT WHAT AGE?____________________________________

HAVE THE ADENOIDS BEEN REMOVED?__________________ AT WHAT AGE?____________________________________

DOES/DID THE PATIENT SUCK A THUMB/FINGERS?________ UNTIL WHAT AGE?__________________________________

ARE THERE ANY SPEECH PROBLEMS?____________________ IS THE PATIENT HAVING SPEECH THERAPY?_________

WHEN WAS THE PATIENT'S LAST DENTAL EXAMINATION?____

WERE THE NECESSARY FILLINGS AND A TOOTH CLEANING COMPLETED THEN?________________________________

HAS THE PATIENT EXPERIENCED A SUDDEN INCREASE IN HEIGHT?____

IF THE PATIENT IS MALE, HAS HIS VOICE CHANGED?____

IF THE PATIENT IS FEMALE, HAS SHE STARTED HER MONTHLY PERIOD?_______________________________________

CURRENT HEIGHT_____________________________________ CURRENT WEIGHT__________________________________

FATHER'S HEIGHT_____________________________________ MOTHER'S HEIGHT_________________________________

IS THERE ANYTHING ELSE IN THE PATIENT'S MEDICAL OR DENTAL HISTORY YOU FEEL WE SHOULD BE AWARE OF?____________ PLEASE DESCRIBE____

SIGNATURE OF PARENT/GUARDIAN:___________________________________