

CERTIFIED SPECIALISTS
IN ORTHODONTICS

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CHILD MEDICAL HISTORY FORM

PATIENT'S FULL NAME _____ NAME PATIENT
PREFERS _____ DATE _____

BIRTHDATE: MONTH _____ DAY _____ YEAR _____ AGE _____ SEX _____

ADDRESS _____ CITY _____ P. CODE _____ PHONE _____

SCHOOL _____ GRADE _____

FATHER'S NAME _____ OCCUPATION _____

EMPLOYER _____ BUS. ADDRESS _____ BUS. TEL. _____

MOTHER'S NAME _____ OCCUPATION _____

EMPLOYER _____ BUS. ADDRESS _____ BUS. TEL. _____

PARENT'S MARITAL STATUS _____ DO YOU HAVE ORTHODONTIC INSURANCE COVERAGE? _____

PERSON(S) RESPONSIBLE FOR ACCOUNT _____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

PATIENT'S DENTIST _____ PHYSICIAN _____

REFERRED BY _____

HAS PATIENT EVER HAD ORTHODONTIC TREATMENT BEFORE? _____

ARE THERE OR HAVE THERE BEEN OTHER MEMBERS IN THE FAMILY UNDER ORTHODONTIC TREATMENT? _____

REASON(S) FOR SEEKING ORTHODONTIC TREATMENT _____

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? _____

WHAT, IF ANYTHING, DO YOU FEEL IS WRONG WITH THE WAY YOUR CHILD'S TEETH LOOK OR FUNCTION? _____

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 _____