Child Health History

Patient's Name:_____ Date:_____

Birthdate:_____ Age:_____

School:_____

Siblings/Age:_____

Wood Orthodontics

CREATING SMILES FOR A LIFETIME

Dental History

Y	N	
☐	☐	Has your child ever had a bad dental experience?
☐	☐	Has your child ever knocked out or chipped any teeth?
☐	☐	Has your child ever been informed of extra or missing teeth?
☐	☐	Is your child's mouth sensitive to temperature or pressure?
☐	☐	Does your child brush his/her teeth daily?
☐	☐	Does your child floss regularly?
☐	☐	Do your child's gums bleed when he/she brushes?
☐	☐	Does your child predominantly breathe through his/her mouth?
☐	☐	Does your child require antibiotic premedication?
☐	☐	Does your child have a tongue thrust or suck his/her thumb?
☐	☐	Does your child experience pain or tenderness in his/her jaw?
☐	☐	Does your child have popping/clicking in his/her TMJ?
☐	☐	Does your child clench or grind his/her teeth?
☐	☐	Has your child experienced chronic ringing in his/her ears?
☐	☐	Does your child have "tension" headaches?
☐	☐	Does your child have any difficulty chewing/swallowing food?
☐	☐	Does your child's bite feel uncomfortable?

What is your child's (or parent's) primary concern with his/her teeth?

_____

Indicate your child's feelings/attitude towards having orthodontic treatment:

☐ Wants treatment ☐Understands treatment is necessary

☐Unwilling but agrees ☐Uncooperative

Has an orthodontist previously been consulted? _____

If yes, whom? _____

Is there any dental work you are aware of that needs completion before orthodontic treatment? _____

Approximate date of most recent dental exam: _____

Has your child had any injuries to his/her face, mouth, teeth or chin?_____

Has anyone else in your family had orthodontic treatment?_____
If yes, how do they feel about the results?_____

What are some of your child's hobbies?_____

Medical History

Y	N	
☐	☐	Abnormal Bleeding/Hemophilia
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asthma/Hay fever
☐	☐	Birth Defects
☐	☐	Blood Disorders
☐	☐	Bone Disorders
☐	☐	Congenital Heart Defect
☐	☐	Depression/Mental Illness
☐	☐	Diabetes
☐	☐	Dizziness
☐	☐	Endocrine Problems
☐	☐	Epilepsy
☐	☐	Gastrointestinal Disorders
☐	☐	Heart Problems
☐	☐	Heart Murmur
☐	☐	Hepatitis/Liver Problems
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	HIV+/AIDS
☐	☐	Kidney Problems
☐	☐	Nervous Disorders
☐	☐	Pneumonia
☐	☐	Prolonged Bleeding
☐	☐	Radiation/Chemotherapy
☐	☐	Rheumatic Fever
☐	☐	Tuberculosis
☐	☐	Tumor/Cancer
☐	☐	Other:_____

_____

Female Patients:

Has patient begun menstruation?_____

If yes, list month/year: _____

Male Patients:

Has patient's voice changed?_____

If yes, list month/year: _____

Has your child ever had an allergic reaction to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Tetracycline
☐	☐	Codeine	☐	☐	Latex	☐	☐	Metals:_____
☐	☐	Dental Anesthetics	☐	☐	Penicillin	☐	☐	Others:_____

Has your child ever had to take antibiotics prior to a dental visit or checkup? _____

Has your child been diagnosed with any emotional disorders, including ADD/ADHD? _____

Please list all medications that your child is currently taking: _____

_____

Is your child currently under the care of a physician? If yes, please explain: _____

_____

Please explain any medical conditions that your child has had in the past: _____

_____

I have read and I understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical/dental status.

We will discuss your treatment with parents / legal guardians / person(s) financially responsible for your treatment / referring doctor / dentist for the furtherment of your treatment.

_____

Signature of parent / legal guardian Date

Medical History Updates or Changes

Date: _____ Date: _____

Comments: _____ Comments: _____

_____ _____

_____ _____

_____ _____

_____ _____

Signature: _____ Signature: _____

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