FAMILY ORTHODONTIC CARE, P.C.
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Child Health & History Form
(PLEASE PRINT & BRING WITH YOU TO APPOINTMENT)

Date: ____/____/____

Patient's Last Name ______________________ First ______________ MI ________
Nickname ______________ Street Address ______________________
City ______________ State ________ Zip Code ______________
Home Phone No ______________ DOB ____/____/____ Age ______ Sex ______
Whom may we thank for referring you to our office ______________________
In Case We Cannot Reach You-Person to contact ______________ Phone ______________
Name & Address of Family Dentist ______________________
Name & Address of Family Physician ______________________
Patient Current Weight ________ Patient Current Height ________
Current Medications ______________________
Has patient ever been hospitalized? Yes / No (if yes, reason) ______________
Does patient have any allergies? Yes / No (if yes, explain) ______________
Does patient have a condition requiring antibiotic prophylaxis before dental procedures? Yes / No (if yes explain) ________
____
Has the patient reached puberty? Yes / No   Girl - Has she started menstruation? Yes / No
Boy - Has his voice changed? Yes / No
Name and Age of other children in the family ______________________
Hobbies, Sports & Musical Instruments? ______________________
Are you aware that some orthodontic visits will be during school hours? Yes / No
School ______________________

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For the following questions circle yes, no or don't know/understand (dk/u). This information is for office use only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Yes No dk/u Does patient follow directions?
Yes No dk/u Does patient brush his/her teeth conscientiously?
Yes No dk/u Does patient have learning disabilities or need extra help with instructions?
Yes No dk/u Is patient sensitive or self-conscious?

Medical History

Yes No dk/u Birth defects or hereditary problems?
Yes No dk/u Bone fractures or major accidents?
Yes No dk/u Rheumatoid or arthritic conditions?
Yes No dk/u Endocrine or thyroid problem?
Yes No dk/u Kidney problems?
Yes No dk/u Diabetes?
Yes No dk/u Cancer or been treated for a tumor?
Yes No dk/u Stomach ulcer or hyperacidity?
Yes No dk/u Polio, mono, tuberculosis, pneumonia?
Yes No dk/u Problems with immune system?
Yes No dk/u AIDS or HIV positive?
Yes No dk/u Hepatitis, jaundice, or liver problem?
Yes No dk/u Fainting spells, seizures, epilepsy, or neurological problems?
Yes No dk/u Mental Health or behavioral problems?

Please Continue On Reverse

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Yes No dk/u Vision, hearing, tasting, or speech difficulties?
Yes No dk/u Cardiovascular problems, rheumatic heart disease, heart murmur?
Yes No dk/u Does patient currently or ever had a substance abuse problem?
Yes No dk/u Other physical problem or symptom? ____________________
Yes No dk/u Being treated by another health care professional? For____________________
Date of last physical exam ____________________

Dental History

Yes No dk/u Started teeth very early or late?
Yes No dk/u Primary (baby) teeth removed that were not loose?
Yes No dk/u Permanent or "extra" teeth removed?
Yes No dk/u Supernumerary (extra) or congenitally missing teeth?
Yes No dk/u Chipped or otherwise injured permanent teeth?
Yes No dk/u Teeth sensitive to hot or cold; teeth throb or ache?
Yes No dk/u Jaw fractures, cysts or mouth infections?
Yes No dk/u "Dead teeth" or root canal treatment?
Yes No dk/u Bleeding gums, bad taste, mouth odor?
Yes No dk/u Periodontal "Gum problems"?
Yes No dk/u Food impaction between teeth?
Yes No dk/u "Gum boils", frequent canker sores, cold sores?
Yes No dk/u Is child taking any forms of fluoride?
Yes No dk/u Thumb finger sucking habit? Until __________
Yes No dk/u Abnormal-swallowing habit (tongue thrusting)?
Yes No dk/u History of speech problem?
Yes No dk/u Mouth breathing habit, snoring, difficulty in breathing?
Yes No dk/u Tooth grinding, jaw clenching, clicking, locking?
Yes No dk/u Any pain in jaws or ringing in ears?
Yes No dk/u Any pain or soreness in muscles of the face, or around the ears?
Yes No dk/u Difficulty in chewing or jaw opening?
Yes No dk/u Aware of loose, broken or missing restorations (fillings)?
Yes No dk/u Any teeth irritating cheek, lip, tongue, palate?
Yes No dk/u Concerned about spaced, crooked, protruding teeth?
Yes No dk/u Aware or concerned about under or over developed jaw?
Yes No dk/u Any relative with similar tooth or jaw relationships?
Yes No dk/u Any "wisdom tooth" problems?
Yes No dk/u Has patient ever had a prior orthodontic examination or treatment?

Date of last dental visit ____________________ Any radiographs taken? ____________________

What would your child like to gain by orthodontic treatment?

- ☐ Eliminate dental crowding
- ☐ Treat overbite
- ☐ Treat underbite
- ☐ Correct my profile
- ☐ Move teeth so that bridges or implants can be made
- ☐ Easier cleaning teeth
- ☐ A nice smile
- ☐ Other ____________________

I have answered these questions truthfully, and to the best of my knowledge. If there are any changes in my child's health/history information I will inform this practice.

Signature of Parent/Guardian ____________________ Date ____________________