Child Dental/Medical Health History Form

Craig & Streight
ORTHODONTICS
Robi Lynn Craig, DDS
Ryan Streight, DDS, MS

Patient's Name: _____ Date: _____
(first) (middle) (last)

General

YES	NO	
☐	☐	Does your child follow directions well?
☐	☐	Does your child have a learning disability or need extra help with instructions?
☐	☐	Is your child sensitive or self-conscious?
☐	☐	Are you aware that some appointments will be during school/work hours?

_____

Dental

YES	NO	
☐	☐	Has your child ever experienced an unfavorable reaction to dentistry?
☐	☐	Has your child ever knocked out or chipped any teeth?
☐	☐	Has your child ever been informed of extra or missing teeth?
☐	☐	Is any part of 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 pre-medication for dental procedures?
☐	☐	Does your child have any kind of finger/thumb or tongue habit?
☐	☐	Has your child ever had pain/tenderness in his/her jaw (TMJ/TMD)?
☐	☐	Is your child aware of jaw clicking or popping?
☐	☐	Has your child been told that he/she clenches or grinds his/her teeth?
☐	☐	Has your child ever experienced chronic ringing in his/her ears?
☐	☐	Does your child have "tension" headaches?
☐	☐	Does your child have difficulty chewing or swallowing food?
☐	☐	Does your child's bite feel uncomfortable?

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

_____

Has your dentist pointed to some orthodontic problem? _____

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

☐ Wants treatment ☐ Understands treatment is necessary

☐ Unwilling but agrees ☐ Uncooperative

Has an orthodontist been previously consulted? _____

_____

Date of your child's most recent dental cleaning/examination: _____

Are you aware of any dental work that needs to be completed prior to orthodontic treatment?

_____

Have there been any injuries to your child's face, mouth, teeth or chin? If yes, please explain: _____

_____

Have any teeth been removed by extraction? If yes, please explain:

_____

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

_____

Medical

Has your child ever had any of the following diseases/medical conditions?

YES	NO	
☐	☐	Abnormal Bleeding / Hemophilia
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asperger Syndrome
☐	☐	Asthma / Hayfever
☐	☐	Autism
☐	☐	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
☐	☐	Latex Allergy
☐	☐	Metal Allergy
☐	☐	Other: _____

(continued . . .)

GROWTH INFORMATION FOR PATIENTS UNDER 16 YEARS OF AGE

Father's Height _____ Mother's Height _____ Adopted? Yes _____ No _____

Patient Resembles: Neither Parent _____ Mother_____ Father_____

Girls: Has she started menstruation? No_____ Yes_____ When? _____

Boys: Has his voice changed? No_____ Yes_____ When? _____

Has your child experienced allergic reactions to any medications? _____

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

Is your child currently taking medication? Please list: _____

_____

Has your child been diagnosed with any emotional disorders, including ADD / ADHD? If yes, please list any medications: _____

_____

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

_____

Please explain any medical problems 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 / persons(s) financially responsible for your treatment referring doctor / dentist for the furtherment of your treatment.

I understand that if I choose to proceed with recommended treatment, the next step includes additional diagnostic records.
I consent to the taking of photographs, models & x-rays for diagnostic purposes.

_____

Signature of parent / legal guardian Date

Medical History Updates or Changes

Date:_____ Date:_____ Date:_____

Comments: _____ Comments: _____ Comments: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Signature: _____ Signature: _____ Signature: _____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions, please do not hesitate to ask us. We are always happy to help.