

## Children's Medical History

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Is your child currently experiencing any health problems? No Yes Explain \_\_\_\_\_

Is your child currently taking medications? No Yes List \_\_\_\_\_

Is your child allergic to any medications? No Yes List \_\_\_\_\_

Has your child's tonsils or adenoids been removed? No Yes When \_\_\_\_\_

Please check if your child has had any of the following conditions:

Heart murmur	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Emotional disorder	<input type="checkbox"/>
Heart surgery	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	HIV positive	<input type="checkbox"/>	Endocrine disorder	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Bone disorders	<input type="checkbox"/>	Growth disorders	<input type="checkbox"/>	Blood disease	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	Developmental disorder	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Fainting	<input type="checkbox"/>

Is there any other condition or problem that you think we should know about? \_\_\_\_\_

Does your son or daughter have (had) a finger sucking habit? No Yes  
Has your son or daughter reached puberty? No Yes  
Girls— menstruation When? \_\_\_\_\_  
Boys—voice changed When? \_\_\_\_\_  
Height \_\_\_\_\_ Do you feel growth is completed? No Yes  
Father's height \_\_\_\_\_ Mother's height \_\_\_\_\_ Adopted? No Yes

## Dental History

Is there any unfinished dental care? No Yes

Is your child apprehensive about dental treatment? No Yes

Has your child had previous orthodontic treatment? No Yes

(With whom:) \_\_\_\_\_

Have either siblings or parents had orthodontic treatment? No Yes

Please check if there is a history of:

Clenching	<input type="checkbox"/>	Muscular soreness around head & neck	<input type="checkbox"/>	Jaw joint soreness	<input type="checkbox"/>
Grinding teeth	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Jaw joint popping/clicking	<input type="checkbox"/>
Ringing in the ears	<input type="checkbox"/>	Speech problems	<input type="checkbox"/>		

Is there any other information that may be helpful? \_\_\_\_\_

I understand that the information that I have given is correct to the best of my knowledge. It will be held in the strictest of confidence per HIPPA regulations. It is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary dental services. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Health history review: \_\_\_\_\_