

EMPRESS ORTHODONTICS

CHILD MEDICAL/DENTAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION

NAME: _____

DATE OF BIRTH (dd/mm/yy): ___/___/___ HOME TELEPHONE: (____) _____ - _____ CELL (____) _____ - _____

ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ POSTAL CODE _____ E-MAIL ADDRESS _____

NAME OF SCHOOL _____

PATIENT'S HEALTH CARD # _____

MEDICAL DOCTOR _____ TELEPHONE (____) _____ - _____

DENTIST NAME & ADDRESS _____ TELEPHONE (____) _____ - _____

DATE OF LAST DENTAL CHECKUP _____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

BILLING INFORMATION

FATHER'S NAME _____

ADDRESS: (if different from patient) _____

CELL: (____) _____ - _____ WORK: (____) _____ - _____ E-MAIL ADDRESS _____

MOTHER'S NAME _____

ADDRESS: (if different from patient) _____

CELL: (____) _____ - _____ WORK: (____) _____ - _____ E-MAIL ADDRESS _____

MARITAL STATUS: Married Single Separated Divorced Widowed

The following information is required to enable us to provide you with the best possible dental care. All the information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please complete the entire form.

1. Is your child being treated for any medical condition at the present or have been treated within the past year?
If yes, please explain?

YES NO

2. When was your child's last medical checkup?

3. Has there been any change in your child's general health in the past year? If yes, please explain?

YES NO

4. Is your child taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list

YES NO

5. **Does your child have any allergies?** If you answered yes, please list using the categories below:

a) medications

YES NO NOT SURE/MAYBE

b) metals, latex/rubber products

c) other e.g. hayfever, foods

6. Is your child being treated for or have ever been treated for:

- | | | | | | |
|---|--|---|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tonsil/Adenoid problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Clenching/ Grinding | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Attention Deficit Disorders | <input type="checkbox"/> Growth problems | <input type="checkbox"/> Immune disease/ HIV | <input type="checkbox"/> Sleep problems/snoring |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Speech/hearing problems | <input type="checkbox"/> Emotional/ Behavioral disorder | <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Cold sores |

7. Are there any conditions or diseases not listed above that your child has or have had? If yes, please explain:
YES NO

8. Is your child having a growth spurt? YES NO NOT SURE/MAYBE

9. Why are you seeking an orthodontic consultation/what don't you like about your child's teeth or bite?

10. Have you consulted an orthodontist previously? YES NO Dr. _____

11. Has your child had previous orthodontic treatment? (Including braces or other appliances) YES NO
If yes, when and by whom: _____

12. Has your dentist told you that your child has missing tooth/teeth or has impacted teeth? YES NO

13. Has your child ever had any serious head or face injuries? YES NO
If yes, explain: _____

14. Does your child have a history of thumbsucking/fingersucking habit? YES NO NOT SURE/MAYBE
If yes, age stopped: _____

15. Is your child a mouthbreather? YES NO NOT SURE/MAYBE

15. Does your child have a strong gag reflex? YES NO NOT SURE/MAYBE

16. Is your child nervous during dental treatment? YES NO NOT SURE/MAYBE

17. Does your child have any brothers/sisters that had orthodontic treatment? YES NO Dr: _____

18. Females: Has your child had her first period: YES NO If yes, when: _____
Males: Has your child's voice changed? YES NO If yes, when: _____

To the best of my knowledge, the above information is correct:

PARENT/GUARDIAN SIGNATURE _____ DATE _____