MEDICAL AND DENTAL INFORMATION (CHILD)

DENTAL HISTORY :

Last visit to the dentist : ( ) 0-6 months ( ) 6-12 months ( ) + 12 months

Reason for orthodontic consultation : _____

Has your child had a previous orthodontic consultation? ( ) yes ( ) no
If yes, did your child have treatment? ( ) yes ( ) no

Is your child apprehensive toward dental visits? ( ) yes ( ) no

Has your child had an accident involving the head or neck area? ( ) yes ( ) no

Has your child had an accident involving the teeth? ( ) yes ( ) no

Has your child had any teeth extractions? ( ) yes ( ) no

Is your child a mouth breather? ( ) yes ( ) no

Does your child have any speech problems? ( ) yes ( ) no

Does your child play a musical instrument? ( ) yes, which one? _____ ( ) no

Do you feel that your child is ready for orthodontic treatment? ( ) yes ( ) no

MEDICAL HISTORY :

Name and phone number of your family physician : _____
Date of your child's last medical exam : _____
Is your child in good health? ( ) yes ( ) no, please explain : _____
Does your child take any medications? ( ) yes, which ones? _____ ( ) no

At what age did your daughter have her period? _____
At what age did your son's voice start to change? _____

Does your child suffer or has your child suffered from…?

Heart trouble ( ) Rheumatic fever ( ) Endocarditis ( ) Anemia ( )
Prolonged bleeding ( ) Frequent colds or sinusitis ( ) Tuberculosis or lung disease ( )
Asthma ( ) Removal of tonsils or adnoids ( ) HIV virus ( )
Emotional problems ( ) Digestive problems ( ) Renal problems ( ) Diabetes ( )
Thyroid ( ) Epilepsy ( ) Skin disease ( ) Ophthalmic disease ( )
Liver disease ( ) Frequent headaches ( ) Fainting ( ) Ear problems ( )
Hay fever ( ) Persistant cough ( ) Mononucleosis ( ) Cancer ( )
Bone disorder ( ) Nervous disorder ( ) Endocrine problems ( )
Allergies : food _____medication : _____latex : ( ) yes ( ) no

Parent's signature : _____ Date : _____