

MEDICAL INFORMATION RECORD - CHILD

Patient's Name _____
(First) (M.I.) (Last)

Nickname or Preferred Name _____ Birth Date _____ Age _____ Sex: M F

Address _____

City _____ Postal Code _____

Tel _____ Bus. or Mobile _____ Email _____

Patient's Dentist _____ Patient's Physician _____

Patient's Mother

Name _____

Employer _____

Occupation _____

Bus. Address _____

Bus. or Mobile Tel. _____

Email _____

Patient's Father

Name _____

Employer _____

Occupation _____

Bus. Address _____

Bus. or Mobile Tel. _____

Email _____

Who is legally responsible for this patient?

Who will be responsible for the financial arrangements?

How did you become acquainted with our office?

Please describe the reason(s) for seeking orthodontic treatment:

CHILD'S MEDICAL HISTORY

The following information is required to enable us to provide your child with the best possible care. All information is strictly private, and is protected by doctor-patient confidentiality. The orthodontist will review the medical history and explain any questions that you do not understand.

Please fill out the entire form (both sides).

1. Is your child being treated for any medical condition at this time or has your child been treated for a medical condition within the past two years? Yes No

If yes, please explain:

2. When was your child's last medical check-up?

3. Has there been a change in your child's health within the past two years? Yes No
If yes, please explain:

4. Is your child currently taking any medications, non-prescription drugs, or herbal supplements? Yes No
If yes, please explain:

5. Does your child have any allergies? Yes No
If yes, please list using the categories below:
- a) Medications

- b) Latex and/or rubber by-products

- c) Other (e.g. foods, hayfever)

6. Has your child ever had an adverse reaction to any medications, injections or anaesthetics? Yes No
If yes, please explain:

7. Has your child ever had his/her adenoids and/or tonsils removed? Yes No
8. Has your child ever been diagnosed with asthma? Yes No
9. Has your child ever had a replacement or repair of: a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes No
10. Does your child have a prosthetic or artificial joint? Yes No
11. Does your child have any conditions or therapies that could affect his/her immune system (e.g. leukemia, AIDS, HIV, radiotherapy, chemotherapy)? Yes No
12. Has your child ever had hepatitis, jaundice or a liver disorder? Yes No
13. Does your child have a bleeding problem or bleeding disorder? Yes No
14. Has your child ever been hospitalized for any illnesses or operations? Yes No
If yes, please explain:

15. Has your child ever been diagnosed with the following? (please check any current and past diagnoses that apply)

chest pain, angina	<input type="checkbox"/>	lung disease	<input type="checkbox"/>
rheumatic fever	<input type="checkbox"/>	steroid therapy	<input type="checkbox"/>
heart attack	<input type="checkbox"/>	cancer	<input type="checkbox"/>
mitral valve prolapse	<input type="checkbox"/>	stomach ulcers	<input type="checkbox"/>
heart murmur	<input type="checkbox"/>	arthritis	<input type="checkbox"/>
shortness of breath	<input type="checkbox"/>	seizures/epilepsy	<input type="checkbox"/>
pacemaker	<input type="checkbox"/>	kidney disease	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	thyroid disease	<input type="checkbox"/>
tuberculosis	<input type="checkbox"/>	drug/alcohol dependency	<input type="checkbox"/>
stroke	<input type="checkbox"/>	nervous disorders	<input type="checkbox"/>

16. Are there any conditions or diseases not listed above that your child has had? Yes No
If yes, please explain:

CHILD'S DENTAL HISTORY

1. Is your child nervous during dental treatment? Yes No
2. Is your child a mouth breather while sleeping or awake (or both)? Yes No
3. Has your child ever had a habit such as thumb or finger sucking, nail biting, lip sucking, grinding teeth, or an unusual swallow pattern? Yes No
4. Has your child ever been informed of any missing or extra permanent teeth? Yes No
5. Have there been any injuries to your child's face, mouth, or teeth? Yes No
6. Has your child experienced any jaw joint noises, jaw joint pain, or limited jaw movement? Yes No
7. Has your child previously consulted an orthodontist? Yes No
8. Has any member of your family had orthodontic treatment? Yes No

To the best of my knowledge, the above information is correct. If there is ever a change in my child's health history, or if medications change, I will inform the orthodontist at the next appointment.

When appropriate or necessary, the orthodontist may send and discuss the patient's health information with other involved health professionals.

Date _____

Signature _____

Additional Notes: