

CHILD

Please Answer All Questions

Date _____

(Circle yes or no and print in blanks where required)

Name _____

I. MEDICAL HISTORY

Date of last Medical examination _____ By whom? _____

- 1. Is the patient in general good health at this time? Yes No
2. Was the patient absent more than five days last year due to illness? Yes No
3. Is the patient now or has he/she been under the care of a physician during the past two years (other than routine checks)? Yes No
Reason _____

4. Is the patient receiving any medicine or pills now? Yes No
If so, list _____

5. Has the patient ever had any surgery? Yes No
For what conditions _____

6. The following diseases are of interest to the Orthodontist. Please check any that the patient has had:

- Checkboxes for: Allergies, Anemia, Asthma, Blood disease, Bone disorders, Cerebral palsy, Colds (frequent), Diabetes, Ear infection (frequent), Emotional disorders, Endocrine problems, Epilepsy, Fainting or dizziness, Glaucoma, Heart disease, Hepatitis, High or low blood pressure, Jaundice, Kidney disease, Liver disease, Lung disease, Nervous disorders, Prolonged bleeding, Rheumatic fever, Rheumatism or arthritis, Rickets, Sore throat (frequent), Stomach or intestinal disease, Tuberculosis, Tumors or growths

7. Does the patient have any special conditions not listed above? Yes No
Explain _____

8. Are the patient's height and weight normal for his/her age? Yes No
a. Patient's height _____ Weight _____ Father's height _____ Mother's height _____
b. How many inches has the patient grown in the past year? _____

9. Has the patient reached puberty? Female Age at onset of menses? _____ Yes No

10. Has the patient ever had a serious accident involving head injuries? Yes No

11. Has the patient ever had an unusual reaction to any drug such as penicillin or local anesthetic? What? _____ Yes No

12. Has the patient ever experienced any complications to healing? Yes No

13. Has the patient ever had any X-ray treatments (other than diagnostic)? Yes No

14. Have tonsils and/or adenoids been removed? At what age? _____ Yes No

15. Is the patient on any kind of special diet? Yes No

16. Does the patient have a diet high in sweets or snacks? Yes No

17. Does the patient wear contact lenses? Yes No

18. Evaluate the following as good, fair, or poor

- Cooperation _____ General health _____ Toothbrushing _____
Dental flossing _____ Hearing _____ Vision _____
General attitude _____ Study habits _____

19. Is the patient pregnant? Yes No

