

## Medical and Dental History

Child's Name \_\_\_\_\_ BirthDate \_\_\_\_\_

	Yes	No
Is your child in good health?		
Does your child have a history of major illness? If yes, please explain:		
Other than for check-ups, has your child ever been under a physician's care? If yes, please explain:		
Has your child ever tested positive for hepatitis or HIV?		
Has your child ever been hospitalized? If yes, please explain:		
Has your child ever needed to take antibiotics prior to dental procedures?		
Is your child allergic to latex or nickel?		
Does your child have any allergies or drug sensitivities? If yes, please list:		
Has your child been diagnosed with ADD or ADHD?		
Has your child been diagnosed with any form of autism?		
Is your child currently taking any medication(s)? If yes, please list medication(s) and reason(s) for use:		
Has your child ever sustained trauma to his/her face, mouth, or teeth?		
Does your child have any head, face, mouth or jaw pain?		
Does your child clench or grind his/her teeth?		
Does your child ever experience jaw pain or notice jaw noises (e.g. clicking or popping) when chewing or yawning?		
Does your child have any speech problems?		
Is your child a mouth breather?		
Has your child ever sucked his/her thumb or finger? If yes, until what age?		
Has your child been examined or treated by another orthodontist?		
<b>GIRLS ONLY:</b>		
Is your daughter pregnant?		
Has your daughter had her first period? If yes, at what age?		

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date