CHILD HEALTH HISTORY INFORMATION

Name: _____ Date: _____

What concerns you most about the thought of orthodontic treatment?

□ Appearance □ Cost □ How long □ Will it work □ Other _____

	YES	NO
Has the patient been under a physicians care during the past 2 years? ……...	□	□
Is patient currently under a physicians care? If yes, state illness & duration. …….	□	□
Is patient taking any medications? If so, describe ……	□	□
Has patient had an unusual reaction to any medications? ……	□	□
Is patient allergic to anything? If so, please list ……...	□	□
Has patient had major surgery? If so, please list …….	□	□
Has patient been diagnosed or treated for (please circle): diabetes, epilepsy, asthma, stroke, arthritis, anemia, fainting, rheumatic fever, heart trouble, hepatitis, high blood pressure, emotional disturbances, endocrine disorders, prolonged bleeding or kidney trouble ……	□	□
History of injury to face, head, or teeth? …….....	□	□
History of mouth breathing, finger or thumb sucking? …….....	□	□
Does patient have any speech problems? ……..	□	□
Does patient have difficulty chewing or swallowing? ……..	□	□
Does patient grind or clench teeth during the day or night? ……..……..	□	□
Does patient have any pain or noises when opening or closing mouth? ……..…	□	□
Has anyone in the family had orthodontic treatment? …….....	□	□
Has patient had previous orthodontic consultation or treatment? …….	□	□
Would patient mind wearing braces or headgear? …….....	□	□

What are your main concerns? _____

Additional comments or questions:

_____

_____

_____

Parent Signature: _____