# MEDICAL INFORMATION RECORD - CHILD

**(please complete, print and bring the form to your appointment)**

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 | ☐ | lung disease | ☐ |
| rheumatic fever | ☐ | steroid therapy | ☐ |
| heart attack | ☐ | cancer | ☐ |
| mitral valve prolapse | ☐ | stomach ulcers | ☐ |
| heart murmur | ☐ | arthritis | ☐ |
| shortness of breath | ☐ | seizures/epilepsy | ☐ |
| pacemaker | ☐ | kidney disease | ☐ |
| diabetes | ☐ | thyroid disease | ☐ |
| tuberculosis | ☐ | drug/alcohol dependency | ☐ |
| stroke | ☐ | nervous disorders | ☐ |

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.*

*By signing below I acknowledge that, when appropriate or necessary, the orthodontist may send/discuss the patient's health information with other involved health professionals.*

Date _____

Signature _____

Additional Notes: