

CHILD HISTORY FORM



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Patient Name: _____ Date: _____

Parents Name: _____ Patient Age: _____

Any information you can give us concerning your child is appreciated. If unsure, leave blank.

The more we know about each patient, the more personalized we can be in managing their orthodontic treatment, both at home and in the office.

Motivation For Orthodontic Treatment

What initiated your interest in pursuing orthodontic treatment for your child?

- Dentist Recommendation
 Comments from family/friends
 Appearance
 Prevention of future problems
 Pain
 Second opinion
 Other _____

What aspects of treatment worry you?

- Extractions
 Surgery
 Pain/Discomfort
 Missing School
 Treatment length
 Treatment too early

Your child is interested in:
 metal braces
 clear braces
 Invisalign
 lingual braces
 retainers

How would you describe your child's general attitude towards orthodontics?

- He/She is excited about it
 Okay with it
 Really doesn't want to, but I think it is important
 Doesn't think it is needed

Which of the following do you think your child might have difficulty with during treatment?

- Losing retainers/appliances
 Reminding to wear appliances
 Maintaining good hygiene
 Not eating candy, soda, hard foods, popcorn
 Esthetics/Appearance with braces
 Social Pressure/Teasing

What are your goals for your child's orthodontic treatment?

- Improve self-image
 Prevent future dental problems
 Fix existing problem
 Easier to clean
 Improve smile esthetics

Patients and their general dentists often request changes in bites or faces and relief from pain or discomfort.

Please help us to understand your concerns by checking the following information; please be specific .If unsure, leave blank

Teeth - If your child's teeth could be changed, how would you like them to change? Check all that apply

<input type="checkbox"/> Straighten the front teeth --- <input type="checkbox"/> upper <input type="checkbox"/> lower	<input type="checkbox"/> Eliminate crowding of teeth --- <input type="checkbox"/> upper <input type="checkbox"/> lower
<input type="checkbox"/> Straighten the back teeth --- <input type="checkbox"/> upper <input type="checkbox"/> lower	<input type="checkbox"/> Eliminate spaces between teeth --- <input type="checkbox"/> upper <input type="checkbox"/> lower
<input type="checkbox"/> Move upper teeth --- <input type="checkbox"/> forward <input type="checkbox"/> backward	<input type="checkbox"/> Make the line of upper teeth more level
<input type="checkbox"/> Move lower teeth --- <input type="checkbox"/> forward <input type="checkbox"/> backward	<input type="checkbox"/> Other

Face - If your child's facial appearance could be changed, what would you change?

<input type="checkbox"/> Move upper lip --- <input type="checkbox"/> forward <input type="checkbox"/> backward	<input type="checkbox"/> Make profile of nose --- <input type="checkbox"/> longer <input type="checkbox"/> shorter
<input type="checkbox"/> Move lower lip --- <input type="checkbox"/> forward <input type="checkbox"/> backward	<input type="checkbox"/> Get rid of sag under lower jaw
<input type="checkbox"/> Show --- <input type="checkbox"/> more <input type="checkbox"/> less --- of teeth when smiling	<input type="checkbox"/> Move chin --- <input type="checkbox"/> forward <input type="checkbox"/> backward
<input type="checkbox"/> Show --- <input type="checkbox"/> more <input type="checkbox"/> less --- of gums when smiling	<input type="checkbox"/> Move chin --- <input type="checkbox"/> left <input type="checkbox"/> right
<input type="checkbox"/> Reduce the strain in --- <input type="checkbox"/> chin <input type="checkbox"/> lips --- when lips close	<input type="checkbox"/> See a wider smile
<input type="checkbox"/> Make lips --- <input type="checkbox"/> closer together <input type="checkbox"/> farther apart --- when teeth are touching	<input type="checkbox"/> Other

Symptoms - If your child has pain or discomfort, please be specific about its location; circle the right or left side or both if they apply.

<input type="checkbox"/> My jaw joints --- <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Temples --- <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> In front of ears --- <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> My teeth	<input type="checkbox"/> Eyes --- <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Below ears --- <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> Sinuses	<input type="checkbox"/> Neck --- <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> Above ears --- <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> Other	<input type="checkbox"/> Shoulders --- <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> In ears --- <input type="checkbox"/> right <input type="checkbox"/> left

Oral Hygiene

How many times per day does your child brush? _____

- My child brushes him/herself
 I brush their teeth for them

Do they floss regularly? Yes No

I would consider my child's attitude toward brushing

- A good brusher
 Could be more conscientious
 Needs to make it a priority
 Doesn't think it is important

Cavity Risk Index

- Low – My child has no Fillings
 Moderate – My child has some fillings
 High- My child has needed a lot of fillings

Please also fill out the back of this form

Dental History

Name of your child's dentist: _____ Date of last visit: _____

How familiar is your child with orthodontic treatment?

- Has had braces before
 Another family member has had treatment
 Not very
 Is somewhat familiar
 Has seen an orthodontist before. When? _____

How would you describe your child's general attitude toward dental work?

- Loves it
 Somewhat cautious at first
 Anxious
 Dreads it

Is there any dental work that you know needs to be done?

- Yes No What? _____

Are your child experiencing any pain in his/her teeth, gums, or jaws at this time?

- Yes No Describe: _____

Have any of your child's permanent teeth ever been injured by a fall or trauma?

- Yes No Describe: _____

Has your child ever experienced any pain or tenderness of his/her jaw joint?

- Yes No Describe: _____

Has your child ever fallen and bumped his/her chin, or received a blow to his/her jaws?

- Yes No Describe: _____

Patient's deciduous ("baby") teeth came in

- EARLY AVERAGE LATE

Patient's deciduous ("baby") teeth were lost

- EARLY AVERAGE LATE

Girls (9-14yo)- Has menstruation started yet?

- Yes No If yes, when? _____

Boys (10-15yo)- Has his voice changed yet?

- Yes No If yes, when? _____

Has your child ever experienced?

<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Major Trauma to teeth or mouth	<input type="checkbox"/> Speech Issues
<input type="checkbox"/> Enlarged tonsils/adenoids	<input type="checkbox"/> Teeth grinding or clenching	<input type="checkbox"/> Learning difficulties
<input type="checkbox"/> Excessive Snoring	<input type="checkbox"/> ADHD	<input type="checkbox"/> Oral habits- Lower lip biting
<input type="checkbox"/> Mouth breathing	<input type="checkbox"/> Sleep Apnea/Disturbance	<input type="checkbox"/> Oral habits- chewing on things (i.e. pencils)
<input type="checkbox"/> Thumb/Finger sucking habit	<input type="checkbox"/> Tongue Thrusting	

Please explain:

Also, please list any special interests and hobbies:

Medical History

Name of physician: _____ Date of last visit: _____

Is your child currently being treated for any on-going illnesses? _____

Please describe your child's overall health: Excellent Good Fair Poor

Please list any medications that are/have been taken on a regular basis: _____

Smoking can be a interfere with orthodontic tooth movement. Does your child smoke? Yes No

Please check any that apply:

<input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Allergies _____	Allergy/Adverse Reaction to:	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma		<input type="checkbox"/> Penicillin
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bone Disorders		<input type="checkbox"/> Latex
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores		<input type="checkbox"/> Sulfa Drugs
<input type="checkbox"/> Eating Disorders/Bulemia	<input type="checkbox"/> Epilepsy-Seizures		<input type="checkbox"/> Codeine
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Heart Trouble		<input type="checkbox"/> Nickel or metals
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Learning Disabilities		<input type="checkbox"/> Novocain/Xylocaine
<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Sinus Trouble		<input type="checkbox"/> Iodine
<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Radiation Treatment		<input type="checkbox"/> Aspirin
<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Frequent Headaches		<input type="checkbox"/> General Anesthesia
<input type="checkbox"/> Bronchitis/Tuberculosis	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Other
<input type="checkbox"/> Arthritis/Rheumatoid Arthritis	<input type="checkbox"/> Endocrine Disorders		

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my child's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for my child's clinical examination.

Signature of parent or guardian

Date: