# BRADFORD ORTHODONTICS

## CHILD MEDICAL/DENTAL HISTORY QUESTIONNAIRE

**PATIENT INFORMATION**

**NAME:**. _____

**DATE OF BIRTH** (dd/mm/yy):____/____/____ **HOME TELEPHONE:** (_____)_____-_____ **CELL** (_____)_____-_____

**ADDRESS** _____ **APARTMENT/UNIT NUMBER** _____

**CITY**_____ **POSTAL CODE** _____ **E-MAIL ADDRESS**_____

**NAME OF SCHOOL** _____

**PATIENT'S HEALTH CARD #**_____

**MEDICAL DOCTOR** _____ **TELEPHONE** (_____)_____-_____

**DENTIST NAME & ADDRESS**_____ **TELEPHONE** (_____)_____-_____

**DATE OF LAST DENTAL CHECKUP** _____

**WHOM MAY WE THANK FOR YOUR REFERRAL?** _____

**BILLING INFORMATION**

**FATHER'S NAME** _____

**ADDRESS: (if different from patient)** _____

**CELL**: (_____)_____-_____ **WORK:** (_____)_____-_____ **E-MAIL ADDRESS**_____

**MOTHER'S NAME** _____

**ADDRESS: (if different from patient)** _____

**CELL**: (_____)_____-_____ **WORK:** (_____)_____-_____ **E-MAIL ADDRESS**_____

**MARITAL STATUS:** ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed

**The following information is required to enable us to provide you with the best possible dental care. All the information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please complete the entire form.**

**1.** Is your child being treated for any medical condition at the present or have been treated within the past year? If yes, please explain?

YES ❑ NO ❑

_____

**2.** When was your child's last medical checkup?

_____

**3.** Has there been any change in your child's general health in the past year? If yes, please explain?

YES ❑ NO ❑

_____

**4.** Is your child taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list

YES ❑ NO ❑

_____

**5. Does your child have any allergies?** If you answered yes, please list using the categories below:

a) medications YES ❑ NO ❑ NOT SURE/MAYBE ❑

b) metals, latex/rubber products

c) other e.g. hayfever, foods

_____

**6.** Is your child being treated for or have ever been treated for:

| | | | | | |
|---|---|---|---|---|---|
| ❑ Asthma | ❑ Tonsil/Adenoid problems | ❑ Heart Disease | ❑ Heart murmur | ❑ Clenching/ Grinding | ❑ Rheumatic fever |
| ❑ Anemia | ❑ Hormone problems | ❑ Tuberculosis | ❑ Diabetes | ❑ Cancer | ❑Seizures/epilepsy |
| ❑ Cleft lip/palate | ❑ Skin problems | ❑ Attention Deficit Disorders | ❑ Growth problems | ❑ Immune disease/ HIV | ❑ Sleep problems/snoring |
| ❑ Autism | ❑ Speech/hearing problems | ❑ Emotional/ Behavioral disorder | ❑ Steroid therapy | ❑ Liver disease | ❑ Cold sores |

**7.** Are there any conditions or diseases not listed above that your child has or have had? If yes, please explain:
YES ❑ NO ❑

_____

**8.** Is your child having a growth spurt? YES ❑ NO ❑ NOT SURE/MAYBE ❑

_____

**9. Why are you seeking an orthodontic consultation/what don't you like about your child's teeth or bite?**

_____

**10.** Have you consulted an orthodontist previously? YES ❑ NO ❑ Dr. _____

_____

**11.** Has your child had previous orthodontic treatment? (Including braces or other appliances) YES ❑ NO ❑

If yes, when and by whom: _____

_____

**12.** Has your dentist told you that your child has missing tooth/teeth or has impacted teeth? YES ❑ NO ❑

_____

**13.** Has your child ever had any serious head or face injuries? YES ❑ NO ❑

If yes, explain: _____

_____

**14.** Does your child have a history of thumbsucking/fingersucking habit? YES ❑ NO ❑ NOT SURE/MAYBE ❑

If yes, age stopped: _____

_____

**15.** Is your child a mouth breather? YES ❑ NO ❑ NOT SURE/MAYBE ❑

_____

**15.** Does your child have a strong gag reflex? YES ❑ NO ❑ NOT SURE/MAYBE ❑

_____

**16.** Is your child nervous during dental treatment? YES ❑ NO ❑ NOT SURE/MAYBE ❑

_____

**17.** Does your child have any brothers/sisters that had orthodontic treatment? YES ❑ NO ❑ Dr:_____

_____

**18.** Females: Has your child had her first period: YES ❑ NO ❑ If yes, when: _____
Males: Has your child's voice changed? YES ❑ NO ❑ ❑ If yes, when: _____

_____

**To the best of my knowledge, the above information is correct:**

PARENT/GUARDIAN SIGNATURE_____DATE_____