Child Health History Form

Thompson Orthodontics
819 W. Main Street
Wilmington, OH 45177
(937) 283-2020

Today's Date: _____

Child's Name: _____ Date of Birth: _____
(First) (Middle) (Last)

Has Orthodontic treatment been recommended for the patient? Yes No

If yes, by whom? Family Dentist Family Physician Friend Other

Who referred you to our office? _____

Has patient had any previous orthodontic treatment or consultation? Yes No

If yes, where? _____

Has any member of your family, or a close friend, had Orthodontic treatment? Yes No

If yes, who? _____

Where were they treated? _____

What were their feelings regarding treatment results? Excellent Good Fair Poor

What would you like Orthodontic treatment to do for you? _____

_____

Is the patient self-conscious of his or her teeth? Yes No

What is the patient's attitude toward Orthodontic treatment? Excellent Good Fair Poor

What do you anticipate in the way of patient cooperation? Excellent Good Fair Poor

Does anyone else in the family have a similar Orthodontic problem? Yes No

Number of brothers of the patient: _____ Ages: ( ), ( ), ( ), ( )

Number of sisters of the patient: _____ Ages: ( ), ( ), ( ), ( )

Have any baby teeth or permanent teeth been removed by your dentist? Yes No
Explain_____

Any major falls or accidents involving the head, face, or teeth? Yes No

Has patient had any speech therapy? Yes No

Thumb or finger sucking? Yes No
To what age: _____

Other oral habits (clench, grind, fingernail biting, ice, etc.) Yes No
Explain_____

Patient Name: _____
Today's Date: _____

Health History:

Tonsils removed?	Age_____	Yes	No
Adenoids removed?	Age_____		
Birth defect?	Explain_____	Yes	No
Rheumatic Fever		Yes	No
Drug or other allergies		Yes	No
List allergies: _____			
Diabetes		Yes	No
Heart Condition		Yes	No
Learning Disability, ADD, ADHD, IEP, or other		Yes	No
Explain _____			
Medication(s) taken		Yes	No
Medication List: _____			
Other Medical Concerns		Yes	No
Please explain: _____			

Present Health Excellent Good Fair Poor

If female, has menstruation begun? Yes No
At what age? _____

Has your child ever had serious illness, injury, or hospitalization? Yes No

What and When: _____

In your opinion, do patient's teeth come in: Early On Time Slow/Late

Child's Physician (doctor or pediatrician): ___Dr._____

Date of last visit: _____ Reason: _____

Child's Dentist (for cleanings, cavities, etc): ___Dr._____

Date of last visit to dentist: _____ Reason: _____

Were any problems with the patient's teeth found at that time? Yes No

Does patient make regular visits to the dentist? Yes No

I hereby declare that this form has been completed, accurately and honestly.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____