DR. DANIEL M. T. MA INC.
MEDICAL/DENTAL HISTORY QUESTIONNAIRE – CHILD

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's dental care. All information will be kept completely confidential.

Medical History

Has your child experienced any health problems? ☐No ☐Yes Explain:_____
Any major change in your child's health recently? ☐No ☐Yes Explain:_____
Is your child currently under physician's care? ☐No ☐Yes Explain:_____
Is your child currently taking medications? ☐No ☐Yes List : _____
Is your child allergic to any medications ? ☐No ☐Yes List : _____
Has your child received a blood transfusion ? ☐No ☐Yes Reason: _____
Have your child's tonsils or adenoids been removed? ☐No ☐Yes When : _____

Does your child have or has he/she ever had any of the following conditions?

Heart Murmur……..….	☐No	☐Yes	Hepatitis…….	☐No	☐Yes	Emotional Problems ……	☐No	☐Yes
Heart Surgery.....	☐No	☐Yes	Diabetes…….	☐No	☐Yes	Frequent Headaches ……...	☐No	☐Yes
Rheumatic Fever ……	☐No	☐Yes	Kidney Disease ….	☐No	☐Yes	Nervous/Anxiousness ….	☐No	☐Yes
Endocrine Disorders ….	☐No	☐Yes	Liver Disease	☐No	☐Yes	Cancer	☐No	☐Yes
Prolonged Bleeding ……	☐No	☐Yes	Tuberculosis	☐No	☐Yes	Bone Disorders	☐No	☐Yes
Anemia	☐No	☐Yes	Bronchitis	☐No	☐Yes	Growth Disorders	☐No	☐Yes
Blood Disease	☐No	☐Yes	Asthma	☐No	☐Yes	Mouth Breather	☐No	☐Yes
Developmental Disorder	☐No	☐Yes	Epilepsy	☐No	☐Yes	Herpes (Fever Blisters)	☐No	☐Yes
Hives/Rash	☐No	☐Yes	Fainting	☐No	☐Yes	Tonsillitis	☐No	☐Yes

Is there any other condition or problem that you think we should know about? _____
_____
_____

Growth Information for Patients Under 16 Years of Age

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives:

Has your son or daughter reached puberty? ☐No ☐Yes
Girls – has she started menstruation? ☐No ☐Yes When? _____
Boys – has his voice changed? ☐No ☐Yes When? _____
Height _____Do you feel growth is completed? ☐No ☐Yes
Father's Height _____ Mother's Height _____
Have either siblings or parents had orthodontic treatment? ☐No ☐Yes With whom : _____

Dental History

Frequency of dental check ups : Twice a year☐ Once a year☐ Only if a problem exists☐ Never☐ Date of last Visit_____
Is there any unfinished care to be completed with your child's dentist? ☐No ☐Yes Explain: _____
Is your child frightened about dental treatment ? ☐No ☐Yes Explain: _____
Has your child had an unpleasant experience in a dental office? ☐No ☐Yes Explain: _____
Has your child had any facial or dental injuries? ☐No ☐Yes Explain: _____
Is there any history of thumb or finger sucking? ☐No ☐Yes Stopped ?_____
Does your child play any musical instruments? ☐No ☐Yes What instrument? _____
Has your child had an orthodontic consultation before? ☐No ☐Yes With whom ? _____
Have teeth (either primary or permanent) been removed? ☐No ☐Yes Explain: _____
Has your child had any previous orthodontic treatment? ☐No ☐Yes With whom ? _____
Are you satisfied with prior treatment? ☐No ☐Yes Explain: _____

Is there any other information that may be helpful? _____
_____

_____ _____ _____
Parent's/Guardian's Signature Date Reviewed By