



Patient's Name Birth Date

Address

Phone

MINOR CONFIDENTIAL MEDICAL HISTORY

I. PLEASE CIRCLE THE APPROPRIATE ANSWER. (Leave blank if you do not understand the question)

1 Yes No Does your child have any health issues? If Yes, explain.

2 Yes No Has there been a change in your child's health within the last year? If Yes, explain.

3 Yes No Has your child gone to the hospital/emergency room or had a serious illness in the past three years? If Yes, explain.

4 Yes No Is your child being treated by a physician now? If Yes, explain.

Date of last medical exam Reason for exam

5 Yes No Has your child had problems with prior dental treatment? If Yes, explain.

Date of last dental exam Name of previous dentist.....

6 Yes No Have there been any injuries to the face, mouth, teeth or chin? If Yes, explain.

7 Yes No Has your child experienced any of the following: Mouth breathing, nail biting, speech problems, thumb/finger sucking, tongue thrust? If Yes, explain.

8 Yes No Has your child ever been evaluated or had orthodontic treatment before? If Yes, explain.

9 Yes No Have your child's adenoids or tonsils been removed? If Yes, explain.

10 Yes No Has your child been informed of any missing or extra permanent teeth? If Yes, explain.

11 Yes No Is your child in pain now? If Yes, explain.

II. PLEASE CHECK IF YOUR CHILD HAS EXPERIENCED ANY OF THE FOLLOWING:

- Chest pain (angina) Blood in stools Frequent vomiting Fainting spells
Diarrhea or constipation Jaundice Recent significant weight loss Frequent urination
Dry mouth Fever Difficulty urinating Excessive thirst
Night sweats Ringing in ears Difficulty swallowing Persistent cough
Headaches Swollen ankles Coughing up blood Dizziness
Joint pain or stiffness Bleeding problems Blurred vision Shortness of breath
Blood in urine Bruise easily Sinus problems

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III. PLEASE CHECK IF YOUR CHILD HAS HAD OR HAS ANY OF THE FOLLOWING:

- Heart disease, Osteoporosis, Heart attack, Stomach problems or ulcers, Tumors or cancer, Sexually transmitted disease, Canker or cold sores, Liver disease, Kidney/bladder disease, Cosmetic surgery, AIDS/HIV, Hospitalization, Artificial joint, Hepatitis, Heart murmurs, Rheumatic fever, Skin disease, High blood pressure, Seizures, Eating disorders, Psychiatric care, Family history of heart disease, Diabetes, Family history of diabetes, Chemotherapy, Radiation, Anemia, Emphysema/other lung disease, Stroke, Tuberculosis, Surgeries, Thyroid disease, Asthma, Heart defects, Herpes, Arthritis/rheumatism, Hardening of arteries, Eye disease, Transplants

IV. PLEASE CHECK IF YOUR CHILD IS ALLERGIC TO, OR HAS HAD A REACTION TO ANY OF THE FOLLOWING:

- Aspirin, Demerol, Percodan, Food, Valium, Vicodin, Latex, Nitrous oxide, Tetracycline, Codeine, Local anesthetic (Novacaine or Xylocaine), Erythromycin, Darvon, Penicillin, Metal/Plastics

Please list other allergies:

V. PLEASE CHECK IF YOUR CHILD IS TAKING OR IN THE LAST THREE MONTHS, HAS TAKEN ANY OF THE FOLLOWING:

- Recreational drugs, Alcohol, Bisphosphonate (Fosamax), Tobacco in any form, Supplements, Over-the-counter medicines, Weight loss medications, Antibiotics, Aspirin

Please list other allergies:

VI. ALL PATIENTS (PLEASE CIRCLE)

- 1 Yes No Does your child have or had any other diseases or medical problems NOT listed on this form? If Yes, explain.
2 Yes No Has your child ever been pre-medicated for dental treatment? If Yes, why?
3 Yes No Has your child ever taken Fen-phen? If Yes, when?
4 Yes No Is there any issue or condition that you would like to discuss with the orthodontist in private?

VIII. PLEASE LIST ALL THE MEDICATIONS THAT YOUR CHILD IS CURRENTLY TAKING:

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RELEASE AND ASSIGNMENT

The practice of dentistry involves treating the whole person. If the orthodontist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of orthodontic treatment.

I authorize the orthodontist to contact the child's physician.

Parent or Guardian's Signature *Date*

Physician's Name *Phone Number*

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my child's health and /or medication dosage. Furthermore, I will not hold my orthodontist, or any other member of her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Parent or Guardian's Signature *Date*

Orthodontist Signature *Date*