

Child Patient Information

Date _____

Patient's Name _____
Last First Middle

Age _____ Number of children in family _____
years mos.

School _____ Grade _____

Patient's Physician _____

Patient's Dentist _____

Medical / Dental Information

MEDICAL HISTORY (circle yes or no and fill in blanks where required)

1. Is the patient in good health?	Yes	No
2. Have tonsils and/or adenoids been removed? At what age? _____	Yes	No
3. Has the patient reached puberty?	No	Yes
4. Are height and weight normal for age?	Yes	No
5. Frequent colds, sore throat, or ear infections?	No	Yes
6. Any history of major illness? If yes, list _____	No	Yes
7. Any allergies or drug sensitivity? If yes, list _____	No	Yes
8. Taking medication now? If yes, list _____	No	Yes
9. Under medical care now? Reason _____	No	Yes

10. Circle any of the following for which the patient has been treated:

Hepatitis	AIDS	Emotional Problems	Fainting
Diabetes	Asthma	Prolonged Bleeding	Convulsions
Arthritis	Epilepsy	Nervous Disorders	Brain Injury
Heart trouble	Rheumatic Fever	Endocrine Problems	Tuberculosis

11. Does the patient have any special problems not listed above?

No Yes

Explain: _____

DENTAL HISTORY (circle yes or no and fill in blanks where required)

1. Date of last dental exam _____	Is work completed?.	Yes	No
2. Have there been any injuries to the face, mouth or teeth?		No	Yes
3. Has patient ever sucked thumb or fingers? Until what age? _____		No	Yes
4. Has patient ever had oral habits, such as lip biting or tongue thrusting?		No	Yes
5. Does patient have any speech problems?		No	Yes
6. Has patient ever had any speech therapy?		No	Yes
7. Is the patient a mouth breather while asleep or awake?		No	Yes
8. Are you aware of any missing or extra permanent teeth?		No	Yes
9. Has an orthodontist been consulted previously?		No	Yes
10. Have either parents or other children in your family had orthodontic treatment?		No	Yes
11. Has anyone in your family been previously treated by Dr. Paulos?		No	Yes
12. Would you consider the patient's diet high in sweets?		No	Yes
13. List any musical instruments played _____	How long? _____		
14. What are you or your dentist most concerned about? _____			

15. Other comments _____			
16. Person filling out this form _____ Date _____			