Child Health History Form

Thompson Orthodontics
1450 Columbus Avenue, Suite 101
Washington Court House, OH 43160
740.335.2921

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? 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

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

Any difficulty in breathing through the nose (awake and/or asleep) Yes No

Has patient had any speech therapy? Yes No

Thumb or finger sucking? Yes No

To what age: __________

Other oral habits (fingernail biting, ice, etc.) ____________________________________________
Health History:

- Tonsils and/or adenoids removed:  
  - Yes  
  - No
- Rheumatic Fever:  
  - Yes  
  - No
- Drug or other allergies:  
  - Yes  
  - No
  - List allergies: ______________________
- Diabetes:  
  - Yes  
  - No
- Heart Condition:  
  - Yes  
  - No
- Medication taken regularly:  
  - Yes  
  - No
  - Medication List: _____________________
- Other Medical Concerns:  
  - Yes  
  - No
  - Please explain: ______________________

Health during infancy and early childhood:

- Excellent
- Good
- Fair
- Poor

Present Health:

- Excellent
- Good
- Fair
- Poor

If female, has menstruation begun?:  
- Yes  
- No
  - At what age? __________

Has your child ever had serious illness or injury?:  
- Yes  
- No
  - What and When: ___________________________________________________

In your opinion, do patient’s teeth come in: Early On Time Slow

Child’s Physician: ________________________________

When was the child last seen by a physician?  
- Date: ______________ Reason: ___________________

Child’s Dentist: ________________________________

When was the child last checked by the dentist?  
- Date: ______________ Reason: ___________________
  - Were any problems found at that time?  
    - Yes  
    - No
  - Does patient make regular visits to the dentist?  
    - Yes  
    - No

Signature: ______________________________ Date: ______________

Print Name: ______________________________ Relationship to Patient: _____________________