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.) _____

Patient Name: _____
Today's Date: _____

Health History:

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

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: _____