CHILD'S MEDICAL HISTORY:

Has your child ever had any of the following medical problems?

Y	N	Allergies	Y	N	Convulsion/Epilepsy	Y	N	Lung Problems
Y	N	Anemia	Y	N	Diabetes	Y	N	Mental Disorder
Y	N	Asthma	Y	N	Drug/Alcohol Abuse	Y	N	Nervous System Disorder
Y	N	Bleeding Disorder/Hemophilia	Y	N	Fainting	Y	N	Pregnant
Y	N	Bronchitis	Y	N	Handicap/Disabilities	Y	N	Rheumatic Fever
Y	N	Cancer/Chemotherapy	Y	N	Hearing Impairment	Y	N	Speech Disorder
Y	N	Cerebral Palsy	Y	N	Hepatitis	Y	N	Tuberculosis
Y	N	Congenital Heart Defect	Y	N	HIV/AIDS	Y	N	Tumors/Growths
Y	N	Heart Murmur	Y	N	Hyperactive			

Office use only: Doctor's Comments: ______________________________

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Has your child experienced any other physical or mental disorder that is not listed above? Yes_____ No_____

If Yes, please describe: ______________________________

Has any immediate family member had any of the above? Yes_____ No_____ If Yes, please describe: ______________________________

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Is your child allergic to any of the following drugs:

Y N Penicillin Y N Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs: Yes_____ No_____ If Yes, please list: ______________________________

Is your child presently under the care of a physician for any illness? Yes_____ No_____ If Yes, please list: ______________________________

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List any drugs or medicines presently being taken: ______________________________

Has your child ever been hospitalized? Yes_____ No_____ If Yes, please give reason and date(s) ______________________________

DENTAL HISTORY

Reason for orthodontic consultation ______________________________

Yes No

____ ____ Has an orthodontist been consulted previously? Name:

____ ____ Have you been informed of any missing or extra permanent teeth?

____ ____ Have there been injuries to the face, mouth, or teeth?

____ ____ Does your child have pain with chewing, yawning, or wide opening?

____ ____ Does your child's jaw make noise and is pain associated with the sounds?

____ ____ Has either parent had orthodontic treatment?

Date of last dental examination ______________________________

GROWTH DATA

Yes No

____ ____ Do you feel your child is still actively growing?

____ ____ Females: Has menstruation started? Date:

____ ____ Males: Has there been a voice change or change in facial hair?

May we request release of your child's medical records? Yes_____ No_____

Thank you for your help. If there is any information that you feel might be of value to us in the treatment of your child, please add it here: ______________________________

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Please sign here if we may use your child's name and photo for in-office marketing (newsletters, bulletin board, etc.) ______________________________