Oral Facial Health Care
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Date:_____

Medical / Dental History

Patient's Name: _____ Age: _____ Date of Birth: _____
Parent: _____ Email: _____ Phone: _____

1. Are you (your child) in good health? _____
2. When was your/his/her last physical examination? _____
3. Do you (your child) have a chronic medical condition?_____ Explain_____
4. Have you (your child) ever been hospitalized?_____Explain_____
   _____
5. Do you (your child) have any allergies that you are aware of? _____
   Explain_____
6. Do you (your child) take any medications routinely? _____
   List _____
7. Do you (your child) have any of the following conditions?

Anemia _____	Epilepsy _____	Hepatitis _____
Asthma _____	Fainting spells _____	Kidney disease _____
Cleft palate _____	Heart condition _____	Rheumatic fever _____
Diabetes _____	Heart murmur _____	Speech problem _____

8. Do you (your child) have AIDS or ever tested positively for it? _____
9. Have you (your child) ever had any mental, emotional, or nervous problems? _____
   Explain _____
10. Have you (your child) ever had excessive bleeding or bruise easily? _____
11. Have you (your child) ever been seen by a dentist/hygienist? _____
    Last appointment _____ Explain _____
12. Have you (your child) ever had any of the following dental problems?

Toothache _____	Extractions _____	Cavities _____
Crooked teeth _____	Sensitive to hot/cold _____	Broken, chipped/ knocked
Sensitive to sweets _____	Discolored teeth _____	out teeth _____

    Other dental problems _____
13. Does your child suck his/her thumb or fingers? _____
14. Do you consider yourself (your child) to be a mouth breather?_____Day_____Night_____
15. Have you (your child) ever been seen by an orthodontist?_____When?_____Who_____
16. Have you (your child) ever had any form of orthodontic appliance?_____

PLACE A CHECK BY AREAS RELATING TO PATIENT'S HISTORY:

_____Normal Labor; #of hrs ____	_____Behavioral difficulties	_____Indigestion
_____Hard labor;# of hrs_____	_____Allergies	_____Smoker
_____C-section; complications___	_____Allergy Medication	_____Use of social drugs
_____Full Term weeks_____	_____Asthma	_____Frequent alcohol use
_____Premature weeks_____	_____Frequent upper respiratory infections	_____Orthodontic relapse
_____Forceps delivery_____	_____TMJ Symptoms	_____Gets daily exercise
_____Colic – Duration _____	_____Headaches	_____Taking medications
_____Breast Fed – Duration_____	_____Ear ringing	_____Good diet
_____Bottle Fed - Duration_____	_____Diabetes	_____Dietary concerns
_____Pacifier - Yrs._____	_____Hypoglycemia	_____Craves sweets
_____Thumb Sucking – Yrs_____	_____Heart condition	_____Is a happy person
_____Finger Sucking – Yrs_____	_____Hearing loss	_____Is fearful
_____Tongue Sucking – Yrs_____	_____Epilepsy	_____Hyperactivity
_____Blanket /Special objects___	_____Neurological condition	_____Follows direction
_____Learning difficulties	_____Muscular disorder	_____Is well organized
_____Coordination difficulties	_____Speech imbalances	_____Is a disciplined typ

_____

Signature (Patient/Parent/Guardian) Date