nu smile ORTHODONTICS

MEDICAL and DENTAL HISTORY QUESTIONNAIRE – CHILD

PATIENT NAME: _____ DATE OF BIRTH: _____

Name of child's physician: _____ Phone: _____

Name of child's dentist: _____ Date of last exam: _____

Mother's name: _____ Address: _____

Home phone: _____ Work: _____ Cell: _____

Father's name: _____ Address: _____

Home phone: _____ Work: _____ Cell: _____

Marital status: ◯ Married ◯ Single ◯ Separated ◯ Divorced ◯ Widowed

1. **Why are you seeking an orthodontic consultation/ what don't you like about your child's teeth or bite?**
   _____
2. Does your child have any health problems? ◯ Yes ◯ No
   If yes, explain: _____
3. Has your child had any serious head or face injuries? ◯ Yes ◯ No
   If yes, explain: _____
4. Does your child have any allergies? ◯ Yes ◯ No
   If yes, please list what they are allergic to: _____
5. List past medications taken by the child: _____
6. List medications the child is now taking: _____
7. Has your child ever been treated for:

a. Tonsil/Adenoid problems	◯ Yes	◯ No	k. Attention Deficit disorders	◯ Yes	◯ No
b. Heart murmur	◯ Yes	◯ No	l. Arthritis	◯ Yes	◯ No
c. Heart disease	◯ Yes	◯ No	m. Seizures	◯ Yes	◯ No
d. Rheumatic Fever	◯ Yes	◯ No	n. Asthma	◯ Yes	◯ No
e. Anemia	◯ Yes	◯ No	o. Cleft lip/palate	◯ Yes	◯ No
f. Osteoporosis	◯ Yes	◯ No	p. Speech/hearing problems	◯ Yes	◯ No
g. Growth problems	◯ Yes	◯ No	q. Radiation therapy	◯ Yes	◯ No
h. Diabetes	◯ Yes	◯ No	r. Sleep problems/snoring	◯ Yes	◯ No
i. Hormone problems	◯ Yes	◯ No	s. Skin problems	◯ Yes	◯ No
j. Cancer	◯ Yes	◯ No	t. Clenching/grinding	◯ Yes	◯ No

8. Is your child having a growth spurt? ◯ Yes ◯ No
9. Is your child adopted? ◯ Yes ◯ No
10. Father's height: _____ Mother's height: _____
11. Have any brothers/sisters had orthodontic treatment? ◯ Yes ◯ No Orthodontist: _____
12. Have you consulted with an orthodontist previously ◯ Yes ◯ No Orthodontist: _____
13. Females: Has your child had her first period? ◯ Yes ◯ No If yes, when: _____
14. Males: Has your child's voice changed? ◯ Yes ◯ No If yes, when: _____
15. Does your child have a history of thumb/fingersucking? ◯ Yes ◯ No If yes, age stopped: _____
16. Is your child a mouthbreather? ◯ Yes ◯ No

If you have dental insurance, please present your insurance information to the receptionist when you arrive.

Signature: _____ DATE: _____

Please email completed form to burnaby@nu-smile.ca (Burnaby location) or terrace@nu-smile.ca (Terrace location).