Medical & Dental History

Physician's Name _____ Address _____

Approximate time of last visit _____ Reason? _____

Please explain: _____

Dentist's Name _____ Address _____

Approximate time of last visit _____ Reason? _____

Please explain: _____

Is your child in Good Health? . . . . . Yes ❑ No ❑

Does your child have any History of Major Illness? . . . . . Yes ❑ No ❑

Please explain: _____

Check any of the following conditions present or past history:

	Yes	No	?		Yes	No	?		Yes	No	?
Diabetes	❑	❑	❑	Tuberculosis	❑	❑	❑	Endocrine Problems	❑	❑	❑
Fever Blisters	❑	❑	❑	Contact Lenses	❑	❑	❑	Prolonged Bleeding	❑	❑	❑
Heart Trouble	❑	❑	❑	Epilepsy	❑	❑	❑	Fainting or Dizziness	❑	❑	❑
Rheumatic Fever	❑	❑	❑	Asthma	❑	❑	❑	Nervous Disorders	❑	❑	❑
AIDS, HIV, ARC	❑	❑	❑	Chicken Pox	❑	❑	❑	Immune Disorders	❑	❑	❑
Bone Disorders	❑	❑	❑	Kidney Involvement	❑	❑	❑	Liver Involvement	❑	❑	❑
Hepatitis	❑	❑	❑	Glaucoma	❑	❑	❑	Cerebral Palsy	❑	❑	❑

Other:

_____

Growth Rate: Slow . . . . . ❑ Average . . . . . ❑ Fast . . . . . ❑

Resembles: Mother . . . . . ❑ Father . . . . . ❑ Adopted . . . . . ❑

Disposition: Obedient . . . . . ❑ Cooperative . . . . . ❑ Independent . . . . . ❑ Rebellious. . . . . ❑

Does your child have a tendency towards . . . . . Colds? ❑ Sore Throats ❑ Ear infections ❑

Have the tonsils and adenoids been removed?. . . . . Yes ❑ No ❑

List any Drugs or Medications now being taken. Give reasons: _____

List any Allergies or Drug Sensitivities: _____

Has your child reached puberty? . . . . . Yes ❑ No ❑

Girls - Has she started menstruating? . . . . Yes ❑ No ❑

Boys - Has his voice changed? . . . . . Yes ❑ No ❑

Height _____ Weight _____

Has there been any Injuries to the Face, Mouth or Teeth? . . . . . Yes ❑ No ❑

Has your child ever sucked a thumb or fingers? . . . . . Yes ❑ No ❑ Until what age? _____

Does your child have any speech problems? . . . . . Yes ❑ No ❑

Is your child a mouth breather? While awake? . . . . . Yes ❑ No ❑

While asleep? . . . . . Yes ❑ No ❑

Have you been informed of any missing or extra permanent teeth? . . . . . Yes ❑ No ❑

Has your child experienced any problems of the jaw:

Clicking of the jaw? . . . . . Yes ❑ No ❑ Difficulty in opening and closing? . . . . . Yes ❑ No ❑

Pain (joint, ear, side of face)?. . . . Yes ❑ No ❑ Difficulty in chewing? . . . . . Yes ❑ No ❑

Has an Orthodontist been consulted previously? . . . . . Yes ❑ No ❑

Has either parent had orthodontic treatment? . . . . . Yes ❑ No ❑

Have any other children had orthodontic treatment? . . . . . Yes ❑ No ❑

List any musical instruments played: _____

Reason for consultation: _____

Consent: The undersigned hereby authorizes Dr. Yee to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by them to make a thorough diagnosis of my child's dental needs. I also authorize Dr. Yee to perform treatments, medication and therapies that may be indicated in connection with (Name of your child) _____. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Signature _____ Date _____ Relationship _____

Medical History Update/Initials _____ / _____ _____ / _____ _____ / _____ _____ / _____