# MEDICAL & DENTAL HISTORY

**Patient's Name** _____ Sex (M/F) _____ Birthdate _____

Pediatrician's Name _____ Address _____

Approx. time of last visit _____ Reason? _____

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

## GENERAL MEDICAL/DENTAL HEALTH (Please elaborate on any "YES" responses)

Does your child have any history of major illness or hospitalization? _____ Yes ❑ No ❑

Has your child had an unfavorable experience with medical or dental treatment? _____ Yes ❑ No ❑

Is your child current on immunizations? _____ Yes ❑ No ❑

Has your child ever had a thumb or pacifier sucking habit? ..... Yes ❑ No ❑ Until what age? _____

List any drugs or medications currently taking (including fluoride). Give reasons: _____

List any allergies or drug sensitivities: _____

**Check "Yes" or "No" for any of the following conditions present or past history:**

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Diabetes | ❑ | ❑ | Tuberculosis | ❑ | ❑ | Endocrine Problems | ❑ | ❑ | Thyroid Disease | ❑ | ❑ |
| Heart Murmur | ❑ | ❑ | Rheumatic Fever | ❑ | ❑ | Prolonged Bleeding | ❑ | ❑ | Mental Disability | ❑ | ❑ |
| Heart Trouble | ❑ | ❑ | Asthma | ❑ | ❑ | Cancer/Radiation TX | ❑ | ❑ | Bone Disorder | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ | Epilepsy/Seizures | ❑ | ❑ | Hepatitis | ❑ | ❑ | Blood Disorder | ❑ | ❑ |
| Anemia | ❑ | ❑ | Hyperactivity/ADHD | ❑ | ❑ | AIDS, HIV, ARC | ❑ | ❑ | Sickle Cell Disease | ❑ | ❑ |
| Transfusions | ❑ | ❑ | Ulcers | ❑ | ❑ | Cerebral Palsy | ❑ | ❑ | Immune Disorder | ❑ | ❑ |

Other health problems: _____

**Consent:** The undersigned hereby authorizes and directs Dr. Brent J. Porter, and his associates, to perform dental examinations; prophylactic cleanings of the teeth and topical fluoride applications; and with proper written or oral notification, any necessary and advisable dental x-rays and/or treatment. I also understand that the use of anesthetic agents embodies a certain risk.

**Signature** _____ **Relationship** _____ **Date** _____

## ORTHODONTIC PATIENTS ONLY! Please complete the following:

| | | | | | | |
|---|---|---|---|---|---|---|
| Growth Rate: | Slow ❑ | Average ❑ | Fast ❑ | | | |
| Resembles: | Mother ❑ | Father ❑ | Adopted ❑ | | | |
| Disposition: | Compliant ❑ | Cooperative ❑ | Independent ❑ | Rebellious ❑ | | |
| Does your child have a tendency towards: | Colds ❑ | Sore Throats ❑ | Ear Infections ❑ | | | |

Has your child's tonsils and adenoids been removed? ..... Yes ❑ No ❑

Does you child have any sinus problems? ..... Yes ❑ No ❑

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

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

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

Has your child suffered any injuries to the face, mouth or teeth? _____ Yes ❑ No ❑

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

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

While awake? ..... Yes ❑ No ❑

While asleep? ..... Yes ❑ No ❑

Have you been informed that your child has any missing or extra permanent teeth? _____ Yes ❑ No ❑

Has your child experienced any problems of the jaw:

Clicking of the jaw? ..... Yes ❑ No ❑

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

Difficulty in opening and closing? ..... 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 instrument played: _____

**Consent:** The undersigned hereby authorizes and directs Dr. Brent J. Porter, and his associates, to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of your child's dental needs, I authorize Dr. Porter to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with my child's treatment and further authorize and consent that Dr. Porter choose and employ such assistance as deemed fit.

**Signature** _____ **Date** _____ **Relationship** _____