Mystic Valley Orthodontics, P.C.

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CHILD HEALTH QUESTIONNAIRE

Welcome to our orthodontic office! In order to provide your child with the best possible care, please complete the following form before your next visit. If you have any questions, please feel free to write them down and the doctor will review the information at your next visit. Your answers are for our records only and are considered confidential. Thank you. ***Please answer ALL questions***

1. Full Name: _____ Date: _____
2. Nickname: _____ Family Dentist: _____
3. Date of Birth: _____ Referred by: _____
4. Mother's Name: _____ Occupation: _____
   Address: _____ City, Zip Code: _____
   Home Phone: _____ Work Phone: _____
   Cell Phone: _____ E-mail: _____
5. Father's Name: _____ Occupation: _____
   Address: __ as above, or: _____ City, Zip Code: _____
   Home Phone: _____ Work Phone: _____
   Cell Phone: _____ E-mail: _____
6. Physician's Name: _____ Physician's Phone: _____
   Address: _____
   Emergency Contact Person: _____
7. Do you have insurance that covers orthodontics? □Yes □ No □ Not sure
   *If yes, Company's Name: _____
   *Subscriber's Number: _____ Social Security Number: _____
   *Subscriber's Date of Birth: _____
8. Do you have Mass. Health coverage? □Yes □ No
   Cardholder Number: _____ Suffix No.: _____
   Recipient Number: _____
9. What do you think is your child's chief orthodontic problem? _____
10. What did your dentist tell you may possibly be done to correct the problem?

_____

*We confirm all of our appointments by email. Please provide us with the best email to contact you:

E-mail Address: _____

*Please check the ***Best*** telephone # to reach you during the day:
Home □ _____
Mother □ Father □ Work □ _____
Mother □ Father □ Cell □ _____

MEDICAL HISTORY

1. Has your child ever had any illnesses of any kind? Yes ___ No ___
   If yes, please give name of illness/es: _____
   _____

2. Has your child ever been hospitalized for any reason? Yes ___ No ___
   If yes, please give reason, age and extent of hospitalization: _____
   _____

3. Does your child take any medications? Yes ___ No ___
   If yes, please list below:

   Name of medication/s: Reason for taking medication/s: Medication dosage and frequency:

   a. _____ _____ _____

   b. _____ _____ _____

   c. _____ _____ _____

   d. _____ _____ _____

4. Does your child have any allergies? If so, please specify _____

5. Has your child ever taken fluoride tablets? If so, when and for how long? _____

6. Are there any problems with speech? If so, please specify _____
   _____

7. Does your child have a problem with tonsils, adenoids, nasal congestion? Yes ___ No __

8. When sleeping, does your child breathe most easily through the nose or mouth?
   _____

9. Is there any reason why we should **NOT** take x-rays on your child? Yes ___ No ___

10. If your child is a girl, has your child had her first menses? Yes____ No ___
    If yes, at what age did it begin? _____

REVIEW OF SYSTEMS

Has your child ever had, or now have any of the following?

Skin

Itching __ Yes __ No
Rash __ Yes __ No
Ulcers __ Yes __ No
Pigmentations __ Yes __ No
Lack/loss of body hair __ Yes __ No
Extremities __ Yes __ No

Extremities

Varicose veins __ Yes __ No
Swollen, painful joints __ Yes __ No
Muscle weakness, pain __ Yes __ No
Bone deformity, fracture __ Yes __ No
Prosthetic joints __ Yes __ No
Osteopoenia __Yes __No
Osteoporisis __Yes __No

Eyes

Blurring of vision __ Yes __ No
Double vision __ Yes __ No
Drooping of eyelid __ Yes __ No
Glaucoma __ Yes __ No

Ear, Nose, Throat

Earache __ Yes __ No
Hearing loss __ Yes __ No
Frequent nosebleeds __ Yes __ No
Sinusitis __ Yes __ No
Frequent sore throat __ Yes __ No
Hoarseness __ Yes __ No

Respiratory

Cough, blood in sputum __ Yes __ No
Bronchitis, emphysema __ Yes __ No
Wheezing, asthma __ Yes __ No
Tuberculosis, exposure to __ Yes __ No

Cardiac

Shortness of breath __ Yes __ No
Pain, pressure in chest __ Yes __ No
Heart attack __ Yes __No
Swelling of ankles __ Yes __No
High/low blood pressure __ Yes __No
Heart Murmur __Yes__ No
Prosthetic valves/pacemaker __Yes __No
Mitral valve prolapse __ Yes __No
Organ transplant __ Yes__No
Rheumatic, scarlet fever __ Yes__No

Gastrointestinal

Difficulty swallowing __ Yes __ No
Abdominal pain, ulcers __ Yes __ No
Jaundice, Hepatitis-A, B, C __ Yes __ No
Liver disease __ Yes __ No
(If so, any RX? & what was RX)

Genitourinary

Difficulty/pain on urination __ Yes __ No
Blood in urine __ Yes __ No
Excessive urination __ Yes __ No
Kidney problems/transplant __ Yes __ No
Sexually transmitted diseases __ Yes __ No

Endocrine

Thyroid trouble __ Yes __ No
Weight change __ Yes __ No
Diabetes __ Yes __ No
Excessive thirst __ Yes __ No
Organ transplant __ Yes __ No
(If yes, which organ? _____)

Hematopoietic

Easy bruising, persistent bleeding __Yes __No
Persistent lymphadenopathy __ Yes __ No
G6PD deficiency __ Yes __ No
Anemia __ Yes __ No
HIV infection, AIDS __ Yes __ No
Leukemia, immune system prob. __ Yes __ No
Spleen problems __ Yes __ No

Neurologic

Frequent headaches __ Yes __ No
Epilepsy, fits __ Yes __ No
Neuritis, neuralgia __ Yes __ No
Parasthesias, numbness __ Yes __ No
Paralysis __ Yes __ No
ADHD __Yes ___No
Autism Spectrum Disorder(ASD) __Yes__No

Psychiatric

Nervousness, irritability __ Yes __ No
Anxiety __ Yes __ No
Depression __ Yes __ No
Nervous breakdown __ Yes __ No

Growth and Tumor

Chemotherapy __ Yes __ No
Radiotherapy __ Yes __ No

***Does your child have a medical condition that requires him/her to need <u>Antibiotic Prophylactic Premedication</u> such as amoxycillin, erythromycin, clindamycin, etc. prior to undergoing dental procedures? Yes_____ or No _____ If yes, please list:**

Name of antibiotic: Reason for taking antibiotic premedication: Dosage and frequency:

_____ _____ _____

DENTAL HISTORY

1. When was the approximate date of the last dental visit? _____

2. What was done at that time? _____

3. Have any dental x-rays been taken within the last six months? Yes ___ No ___

4. Has your child had any extractions of baby or permanent teeth? Which ones and for what reason were they extracted? _____ Dates: _____

5. Have there been any injuries or blows to any of the teeth? Yes ___ No ___

6. Has your child had any toothaches or complaints about sensitivity to hot, cold or sweets in any permanent teeth at any time? _____

7. Has your child ever had or does your child now have any habits such as thumb sucking, nail biting, tongue habits, or grinding the teeth? _____

8. Does your child have any pain, cracking, popping or noise in the jaw joint near the ears? Any pain in the morning? ___ If so, how long has pain persisted? _____

9. Does your child have frequent canker or cold sores? Yes ___ No ___

10. Does your child gag easily? Yes ___ No ___

11. Do you have a family history of any relative/s with a Class III "underbite" malocclusion and facial skeletal growth pattern? Yes _____ No _____
If yes, what is the relationship of the relative/s to your child? _____

SOCIAL HISTORY

1. Family dental history: Please list the names and ages of siblings, starting with the oldest. Also, please describe the dental appearance of each child and whether any have had or may need braces.
   a._____
   b._____
   c._____
   d._____

2. Parents' past dental history: What type, if any, orthodontic problem does each parent have? Has either parent had orthodontic treatment?
   Father: _____
   Mother: _____

3. What school does your child attend and what grade is your child in?
   _____
   How would you rate your child's school performance? _____

4. What are your child's interests? (sports, hobbies, musical instruments, etc.)
   _____

5. What is your child's present feeling about the possibility of having to wear braces? Include whether you think your child will cooperate with brushing and will wear all the appliances faithfully as instructed. _____

6. How would you characterize your child's personality? i.e. apprehensive, sensitive, outgoing, cries easily, etc._____
   _____

7. Is there anything else about your child's medical, dental, social or emotional history that you feel the doctor should know? Include here any comments about sibling rivalry, hyperactivity, emotional conflicts and family problems such as divorce or separation; include anything which might affect your child's motivation and cooperation in wearing braces and keeping appointments._____
   _____

I certify that any and all questions I had about the inquiries above have been answered to my satisfaction and I have answered these questions truthfully and completely. I will not hold my orthodontist, or any other member of his staff responsible for any errors or omissions that I may have made.

In addition, I understand that all treatments, x-rays, laboratory fees and examinations are to be paid for as they are received or definite financial arrangements are to be made in advance.

_____
Name of Patient – Please Print

_____ _____
Patient's Signature or Parent/Guardian (required for patients under 18 yrs.of age) Date

_____ _____
Dentist Signature Date