

CHILD DENTAL HISTORY

Child's Name _____ Date _____

 First Middle Last
Name of child's general dentist or pedodontist _____

Address _____

Name of child's oral surgeon _____ periodontist _____

Date of child's last visit to dentist _____ Frequency of check-ups _____

Frequency of brushing _____ Time of day when child brushes _____

Frequency of flossing _____ Time of day when child flosses _____

Type of toothbrush _____ Type of toothpaste _____

Summarize child's previous dental care _____

Attitude toward previous dental care _____

What is your description of the orthodontic problem _____

Attitude toward possible orthodontic treatment _____

What facial changes would you like see, if any _____

- | | | | |
|----------------------------------|----------------|--|----------------|
| Does child: | | Was child breast fed (age ___ to ___) | Yes ___ No ___ |
| Bite lips | Yes ___ No ___ | Was child bottle fed (age ___ to ___) | Yes ___ No ___ |
| Clench teeth when awake . . . | Yes ___ No ___ | Has child ever: | |
| Grind teeth when asleep . . . | Yes ___ No ___ | Been informed of extra teeth . . . | Yes ___ No ___ |
| Have any sensitive teeth . . . | Yes ___ No ___ | Been informed of missing teeth . . | Yes ___ No ___ |
| Have bleeding or sore gums . . . | Yes ___ No ___ | Consulted other orthodontist . . . | Yes ___ No ___ |
| Have frequent headaches . . . | Yes ___ No ___ | Had an injury to chin | Yes ___ No ___ |
| Have pain in jaw joint | Yes ___ No ___ | Had an injury to face | Yes ___ No ___ |
| Have limited jaw opening . . . | Yes ___ No ___ | Had an injury to head | Yes ___ No ___ |
| Hear sounds in jaw joint . . . | Yes ___ No ___ | Had an injury to mouth | Yes ___ No ___ |
| Hear ringing in ears | Yes ___ No ___ | Had an injury to teeth | Yes ___ No ___ |
| Have speech problems | Yes ___ No ___ | Had any baby teeth extracted . . . | Yes ___ No ___ |
| Mouth breathe when awake . . . | Yes ___ No ___ | Had any second teeth extracted . . | Yes ___ No ___ |
| Mouth breathe when asleep . . . | Yes ___ No ___ | Had jaw lock open or closed . . . | Yes ___ No ___ |
| Play a musical instrument . . . | Yes ___ No ___ | Had previous orthodontic care . . | Yes ___ No ___ |
| Rest on chin | Yes ___ No ___ | Sucked a pacifier (age ___ to ___) . . | Yes ___ No ___ |
| Thrust tongue when swallows . . | Yes ___ No ___ | Sucked finger(s) (age ___ to ___) . . | Yes ___ No ___ |
| Wear partial dentures | Yes ___ No ___ | Sucked thumb (age ___ to ___) . . . | Yes ___ No ___ |

Does child have other oral habits (biting cheeks, fingernails, ice, pencils, etc.) Yes ___ No ___

Does child have brothers/sisters/parents who have had previous orthodontic . . . Yes ___ No ___

May we request child's medical and dental records if necessary Yes ___ No ___

IF YES TO ANY OF THE ABOVE; please describe--when, for what, by whom, from whom, how often, what type, until what age, etc. (use back for additional space) _____

Additional comments _____

Information given by: _____ Date _____

(Signature - relationship to child)