

Cooper Orthodontics

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Medical History:

Has your child ever had any of the following medical problems: Please circle:

- Y N Abnormal Bleeding
- Y N ADD/ADHD
- Y N Allergies to any drugs
- Y N Allergic to latex/metals
- Y N Allergic to Plastic
- Y N Any Hospital Stays
- Y N Any Operations
- Y N Asthma
- Y N Cancer
- Y N Congenital Heart Defect
- Y N Convulsions/Epilepsy
- Y N Diabetes
- Y N Hearing Impairments
- Y N Hepatitis
- Y N Tuberculosis
- Y N HIV/AIDS
- Y N Heart Murmur
- Y N Handicaps/Disabilities

Please discuss any medical problems that your child has had: _____

Has your child ever experienced any of the following:

- Y N Clenching/ Grinding Teeth
- Y N Lip Sucking / Biting
- Y N Mouth Breather
- Y N Nail Biting
- Y N Nursing Bottle Habits
- Y N Speech Problems
- Y N Thumb / Finger Sucking
- Y N Tongue Thrust

What are the main concerns that you would like orthodontics to accomplish?: _____

Has your child ever been evaluated or had orthodontic treatment before? _Y _N

Have there been any injuries to the face, mouth, teeth or chin? _Y _N

List any musical instruments played: _____

Have adenoids or tonsils been removed: _Y _N

Has your child been informed of any missing or permanent teeth? _Y _N

Does your child brush his/her teeth daily? _Y _N

Child's Physician: _____

Phone#: _____ Date of last visit: _____

Is your child currently under the care of a physician _Y _N

Has puberty begun?: _Y _N

Has menstruation begun? _Y _N

PLEASE LIST ALL DRUGS THAT YOUR CHILD IS CURRENTLY TAKING: _____

PLEASE LIST ALL DRUGS/THINGS THAT YOUR CHILD IS ALLERGIC TO: _____

I understand that the information that I have given is correct to the best of my knowledge, that is will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

SIGNATURE OF PARENT OR GUARDIAN

DATE