Patient Number:_____ Date: _____

TINGRINNERS CLUB JAMAICA

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CHILD/ADOLESCENT ORTHODONTIC CONSULTATION

Patient's Name: _____

Age: _____ Date of Birth_____

Home Phone: _____Email Address:_____

Address:_____

_____

Father's Name: _____

Bus.Phone:_____ Father's Occupation:_____

Mother's Name: _____

Bus.Phone:_____ Mother's Occupation:_____

Parent's Marital Status: _____

Who will be responsible for this account? _____

In your own words, what is the problem?_____

_____

MEDICAL HISTORY

Name of child's physician:_____

Address of physician: _____ ___Phone: _____

Date of last examination: _____

Is your child in good health? .....**Yes No Don't know**

Does your child have a health problem? .....**Yes No Don't know**

If "yes" explain:_____

_____

Has your child ever been hospitalized, had general anesthesia, or emergency room visits?

Yes No Don't know

If "yes" explain: _____

_____

Are your child's immunizations up to date? ……**Yes No Don't know**

Allergies (Please list) _____

_____

Past medication taken by child: _____

_____

Daily medication child is now taking: _____

_____

Has your child ever had or been treated by a physician for: (Please circle your response)

Problems at Birth? ……	**Yes**	**No**	**Don't know**
Diabetes? ……	**Yes**	**No**	**Don't know**
Heart murmur? ……	**Yes**	**No**	**Don't know**
Arthritis? ……	**Yes**	**No**	**Don't know**
Heart Disease? ……	**Yes**	**No**	**Don't know**
Cancer? ……	**Yes**	**No**	**Don't know**
Rheumatic Fever? ……	**Yes**	**No**	**Don't know**
Cerebral Palsy? ……	**Yes**	**No**	**Don't know**
Anaemia? ……	**Yes**	**No**	**Don't know**
Seizures? ……	**Yes**	**No**	**Don't know**
Sickle Cell Anaemia? ……	**Yes**	**No**	**Don't know**
Asthma? ……	**Yes**	**No**	**Don't know**
Bleeding/Haemophilia? ……	**Yes**	**No**	**Don't know**
Cleft Palate/Lip? ……	**Yes**	**No**	**Don't know**
Tonsil/Adenoid Problems? ……	**Yes**	**No**	**Don't know**
Speech/Hearing Problems? ….	**Yes**	**No**	**Don't know**
Transfusion? ……	**Yes**	**No**	**Don't know**
Hepatitis? ……	**Yes**	**No**	**Don't know**

AIDS/HIV? ……..,,,,,,,,,,	**Yes**	**No**	**Don't know**
Skin Problems? ……	**Yes**	**No**	**Don't know**
Tuberculosis? ……	**Yes**	**No**	**Don't know**
Sleep Problems? ……	**Yes**	**No**	**Don't know**
Liver Disease? ……	**Yes**	**No**	**Don't know**
Kidney Problems? ……	**Yes**	**No**	**Don't know**
Emotional/Behaviour Problems? …	**Yes**	**No**	**Don't know**
Eye Problems? ……	**Yes**	**No**	**Don't know**

If "yes" to any of the above questions, please explain this or any other problem:

_____

_____

Has your child had any recent rapid growth? _____

If so, how much? _____

PARENTS: Father (Height) _____ (Weight) _____

Mother (Height) _____ (Weight) _____

SIBLINGS: 1. (Height) _____ (Weight) _____

2. (Height) _____ (Weight) _____

FEMALES: Has menstruation begun? …. **Yes** **No**

If yes, when? _____

Pregnant? … **Yes** **No**

DENTAL HISTORY

Has your child seen a Dentist before? _____

Date of last visit: _____

Regular Dentist's name:_____

- Has your child ever experienced any complications following dental treatment?

  Yes **No** **Don't know**
- Has your child had cavities and/or toothaches? **Yes** **No** **Don't know**
- Are your child's teeth sensitive to temperature or food? **Yes** **No** **Don't know**
- Did your child ever get instruction on brushing? **Yes** **No** **Don't know**
- Do your child's gums bleed when brushing? **Yes** **No** **Don't know**

- Does your child use fluoride products - Rinse, Drops? **Yes** **No** **Don't know**
- Has your child had any clicking or pain in the jaw joints? **Yes** **No** **Don't know**

  If "yes" - Explain: _____

  _____
- Has your child inherited any family or dental characteristics? **Yes** **No** **Don't know**

  If "yes" - Explain: _____

  _____
- Has your child ever injured his/her teeth? **Yes** **No** **Don't know**
- Did your child use a pacifier/soother? **Yes** **No** **Don't know**
- Did your child suck a finger or thumb? **Yes** **No** **Don't know**
- Has your child ever had dental x-rays? **Yes** **No** **Don't know**

  Date: _____

Does your child have any other dental problem(s) we should know about?

_____

Child's School:_____ _____

Child's Grade in School: _____

Do you consider your child to be: (Check one [1])

Advanced in learning _____

Progressing normally _____

Slow learner _____

Will your child be uncooperative? ..... **Yes** **No** **Don't know**

If "yes" -Explain: _____

_____

Whom may we thank for referring you to our office? _____

Person completing this form: _____

Relationship with patient: _____