

maria eugenia

YAZJI

DDS • MS

ORTHODONTICS EXCLUSIVELY

Child/Adolescent History

Patient Name _____

What is your chief concern for us at this visit? _____

**Please circle Y (yes) or N (no) for the following questions, whichever applies. Your answers are for our records only and will be considered confidential. Please use the space after the question for additional explanations.

Medical History

- Y N Is the patient in excellent health?
- Y N Has there been any change in the patient's general health within the last year?
- Y N Patient's last physical exam was _____ (month/year)
- Y N Is the patient now under the care of a physician? If so, what is being treated? _____
- Y N Has the patient had a serious illness/hospitalization in the past 5 years?
If so, for what? _____
- Y N Is the patient taking any medication (include non-prescription)? _____

Does the patient have any of the following conditions?

Allergies or drug reactions to:

- | | |
|-------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| Y N Latex | Y N Low blood pressure |
| Y N Penicillin or other antibiotics | Y N Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure, arteriosclerosis, stroke) |
| Y N Sulfa drugs | Y N Damaged or artificial heart valves, including heart murmur or rheumatic heart disease |
| Y N Aspirin, Ibuprofen, Tylenol | Y N Does the patient need pre-medication prior to dental visits? |
| Y N Local anesthetics | Y N Arthritis or joint problems or artificial joints/limbs |
| Y N Codeine or other narcotics | Y N Birth Defects |
| Y N Other _____ | Y N Kidney trouble |
| Y N Respiratory problems, emphysema | Y N Tuberculosis |
| Y N Asthma or hay fever | Y N Bone fractures or trauma to face or jaw |
| Y N Sinus trouble | Y N Vision, hearing or speech difficulty |
| Y N Persistent swollen neck glands | Y N Persistent cough |
| Y N Thyroid or endocrine problems | Y N Frequent colds or sore throats |
| Y N Diabetes | Y N Frequent headaches |
| Y N Hepatitis, jaundice or liver disease | Y N Stomach ulcer or hyperacidity |
| Y N AIDS or HIV infection | Y N Tumor (Cancerous or benign) |
| Y N Sexually transmitted disease | Y N Radiation therapy or Chemotherapy |
| Y N Substance abuse problem (past or present) | Y N Tonsils or adenoids removed? What age? _____ |
| Y N Mental health problem or nervous disorder | Y N Is patient's height and weight normal for his/her age? |
| Y N Fainting spells or seizures | |
| Y N Epilepsy or other neurological disease | |
| Y N Blood disorder such as anemia | |
| Y N Abnormal bleeding or blood transfusion | |
| Y N Does the patient have any disease, condition or problem not listed above that you think we should know about? | |

If so, please explain _____