

Date _____
 Child's Name _____
 Birthdate _____
 Height _____ Weight _____
 What is your relationship to this child? _____

Child Medical History

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Is your child in good health? Yes No
 Has there been any change in your child's general health within the past year? Yes No
 When was your child's last physical examination? _____
 Is your child now under the care of a physician? Yes No
 If so, what condition is your child being treated for? _____
 Your child's physician name and address _____

Address _____	City/State _____	Zip _____
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Has your child ever had any *serious* illness or operation? Yes No
 If so, what was the illness/operation? _____
 Has your child ever had joint replacement surgery? Yes No
 Has your child ever been hospitalized or had a serious illness in the past 5 years? Yes No
 If so, what was the problem? _____
 Does your child have/had any of the following diseases/conditions:

Rheumatic fever/rheumatic heart disease?	Yes	No
Congenital heart lesions?	Yes	No
Cardiovascular diseases?	Yes	No
Pain in the chest upon exertion?	Yes	No
Shortness of breath after mild exercise?	Yes	No
Shortness of breath when lying down/ require extra pillows when he/she sleeps?	Yes	No
Does your child have a cardiac pacemaker?	Yes	No
Had any heart valves replaced?	Yes	No
Had heart bypass surgery?	Yes	No
Allergies?	Yes	No
Sinus trouble?	Yes	No
Asthma/hay fever?	Yes	No
Hives/skin rash?	Yes	No
Fainting spells/seizures?	Yes	No
Diabetes?	Yes	No
Urinate (pass water) more than 6 times a day?	Yes	No
Thirsty much of the time?	Yes	No
Frequent drymouth?	Yes	No
Hepatitis, jaundice or liver disease?	Yes	No
Stomach ulcers?	Yes	No
Kidney trouble?	Yes	No
Tuberculosis?	Yes	No
Does your child have a persistent cough/cough up blood?	Yes	No
Low blood pressure?	Yes	No
Venereal disease?	Yes	No
Other _____		

Has your child ever had abnormal bleeding associated with previous extraction, surgery, or trauma? Yes No
 Does your child bruise easily? Yes No
 Has your child ever required a blood transfusion? Yes No
 If so, please explain _____
 Does your child have any blood disorder such as anemia? Yes No
 Has your child had surgery / x ray treatment for a tumor, growth or other condition of his/her head/neck? Yes No
 Is your child taking any drugs/medication? Yes No
 If so, please list _____
 Is your child taking any of the following:

Antibiotics/sulfa drugs?	Yes	No
Anticoagulants (blood thinners)?	Yes	No
Medicine for high blood pressure?	Yes	No
Cortisone (steroids)?	Yes	No
Tranquilizers?	Yes	No
Antihistamines?	Yes	No
Aspirin?	Yes	No
Insulin, tolbutamide (Orinase) or similar drug?	Yes	No
Digitalis/drugs for heart trouble?	Yes	No
Nitroglycerin?	Yes	No
Oral contraceptive/other hormonal therapy?	Yes	No
Other _____		

Is your child allergic to/had your child ever reacted adversely to:

Local anesthetics?	Yes	No
Penicillin/other antibiotics?	Yes	No
Sulfa drugs?	Yes	No
Barbiturates, sedatives or sleeping pills?	Yes	No
Aspirin?	Yes	No
Iodine?	Yes	No
Codeine/other narcotics?	Yes	No
Other _____		

Has your child had any serious trouble associated with any previous dental treatment? Yes No
 If so, please explain _____
 Does your child have any disease, condition or problem not listed above that you think we should know about? Yes No
 If so, please explain _____
 Is your child employed in any situation which exposes him/her regularly to x rays or other ionizing radiation? Yes No
 Is your child wearing contact lenses? Yes No
Females:
 Is your child pregnant? Yes No
 Does your child have any problem associated with her menstrual period? Yes No

Chief Dental Complaint:

Signature of parent/guardian



PERSONAL INFORMATION

DIPLOMATE OF THE AMERICAN BOARD OF ORTHODONTICS

1821 N. Rock Road / Wichita, Kansas 67206 / (316) 683-6518
9909 W. 21st St. N. / Wichita, Kansas 67205 / (316) 722-0857

J. KENDALL DILLEHAY, D.D.S.

Patient's Name: _____ Sex _____
Last First Nickname

Home Address _____ Phone _____

Date _____ Age _____ Birthdate _____ School _____

1. Responsible Party _____ Relationship _____
Address (If different) _____ Phone _____
Business of Responsible Party _____ Bus. Phone _____
Insurance Co. _____ SS# _____
Policy # _____ Birthdate _____
E-mail _____

2. Responsible party _____ Relationship _____
Address (If different) _____ Phone _____
Business of Responsible Party _____ Bus. Phone _____
Insurance Co. _____ SS# _____
Policy # _____ Birthdate _____

Other Family Members who have been seen by our Doctors: _____

How did you first hear of our office? _____

General Dentist _____

Patient's favorite hobbies and special interests: _____

The American Association of Orthodontists recommends that a child's first visit to an orthodontist should take place when an orthodontic problem is first detected. Depending on the nature of the problem, whether it's jaw growth problems, tooth problems or both, this first visit could take place as early as age 2 or 3, as the primary teeth erupt. Whether or not an orthodontic problem is detected, however, a child should visit an orthodontist for an evaluation no later than age 7. This may surprise you because orthodontic treatment is usually associated with adolescence. Though treatment does not necessarily begin at this early age, an examination is very important to ensure maximum dental health for your child.

If you would like for us to place the names of your younger children in our file for future examination, please list their names and dates of birth below. We will send you a reminder card shortly after their seventh birthday.

NAME _____	DATE OF BIRTH _____
_____	_____
_____	_____
_____	_____
_____	_____