MEDICAL & DENTAL HISTORY – CHILD (UNDER 16 YEARS) *CONFIDENTIAL*

Last Name:	Title:
First Names:	DOB:

Who recommended this practice to you? ☐ Dr _____ ☐ Friend ☐ Website ☐ Sign ☐ Yellow pages ☐ Newspaper ☐ other

Residential Address:	
Suburb:	Postcode:
Mailing Address:	Postcode:
Suburb:	Postcode:

Home Phone: Mobile Phone: Work:

Facsimile: Email:

Person responsible for paying the fees: Health fund ☐ Yes ☐ No (specify)

Address (if different to above):

The name of your Physician (GP)?

Are you currently under medical care?

For what reason?

Do you have a specific reason for attending today? ☐ toothache ☐ broken teeth ☐ missing teeth ☐ facial/jaw/ear pain ☐ braces ☐ clean ☐ check up ☐ headaches ☐ worn teeth ☐ implants ☐ appearance of teeth ☐ bite issues ☐ sleep issues ☐ other_____

CURRENT MEDICATIONS

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs etc.

Medication	Dosage	Reason for taking	Time of day

☐ See attached list * If you require another page for your medication, please ask reception

PREVIOUS TREATMENTS / MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment &/or Medication	Doctor / Provider Name	Approximate Date & Duration of treatment	Success of treatment

On a scale of 1-5, how nervous would you say you are at the dentist?

Completely at ease 1 2 3 4 5 Very Nervous

I release and give my permission for this office to request information and communicate with the providers listed above.

Parent/Guardian Signature ……..:…….Date:……...

Please Print name: …….

Chief complaint: _____

Please tick any of the conditions below that you have or have had

CARDIOVASCULAR		**HAEMATOLOGIC**		**NEUROLOGIC**	
Heart attack		Blood transfusion		Vision problems	
High blood pressure		Anaemia		Glaucoma	
Heart murmur		Haemophilia		Earache, ringing in the ear	
Heart valve disease		Leukaemia		Hearing loss	
Heart surgery		Tendency to bleed longer than normal		Migraines	
Rheumatic fever		Fluid retention		Fainting or dizzy spells	
Congenital heart defect		HIV		Stroke	
Arrhythmias				Epilepsy or seizures	
Aneurysm				Panic attack	
Other heart problems				Phobias	
DERMAL/MUSCULOSKELETAL Cold Sores/Herpes		**PULMONARY**		**OTHER CONDITIONS**	
Allergy to latex (Rubber)		Hay fever		Anxiety disorder	
Skin rash		Sinus trouble		Depression	
Osteoarthritis		Allergies or hives		Enlarge lymph node or gland	
Rheumatoid arthritis		Asthma		Tumor or Cancer	
Systemic Lupus		Chronic cough		Radiation therapy	
Artificial (prosthetic) joint		Emphysema		Chemotherapy	
Fibromyalgia		Chronic bronchitis		Sleep Apnoea	
Chronic Fatigue Syndrome		Tuberculosis (TB)		Infectious disease	
Dry Mouth		Breathing difficulties		Excessive thirst	
Frequently sore throat		Sarcoidosis		Trouble breathing through your nose	
Muscle weakness/Cramps					
ENDOCRINE		**GENITOURINARY**		**GASTROINTESTINAL**	
Diabetes		Kidney, Bladder problem		Stomach/Intestinal ulcers	
Thyroid disease		Reproductive system problem		Colitis	
Hormone replacement therapy (HRT)		Pregnant How many weeks?		Irritable bowel syndrome	
Change of libido				Persistent diarrhoea	
ALLERGIES/FOOD INTOLERANCES ***Please list***				Hepatitis or liver disease	
				Nausea/Vomiting	

HEALTH & MEDICAL HISTORY

1. In the last 30 days, on average, how long did any pain in your jaw or temple area on either side last?
   a.□ No pain b.□ From very brief to more than a week, but it does stop c.□ Continuous
2. In the last 30 days, have you had pain or stiffness in your jaw on awakening?
   □ Yes □ No
3. In the last 30 days, did the following activities change any pain (that is, make it better or make it worse) in your jaw or temple area on either side?

   A. Chewing hard or tough food
      a.□ No b.□ Yes
   B. Opening your mouth or moving your jaw forward or to the side
      a.□ No b.□ Yes
   C. Jaw habits such as holding teeth together, clenching, grinding or chewing gum
      a.□ No b.□ Yes
   D. Other jaw activities such as talking, kissing or yawning
      a.□ No b.□ Yes

Parent/Guardian Initial_____

Paediatric Daytime Sleepiness Scale (PDSS)

Please answer the following questions as honestly as you can by circling one answer only:

1. **How often do you fall asleep or get drowsy during class periods?**

   Always Frequently Sometimes Seldom Never

2. **How often do you get sleepy or drowsy while doing your homework?**

   Always Frequently Sometimes Seldom Never

3. **Are you usually alert most of the day?**

   Always Frequently Sometimes Seldom Never

4. **How often are you ever tired & grumpy during the day?**

   Always Frequently Sometimes Seldom Never

5. **How often do you have trouble getting out of bed in the morning?**

   Always Frequently Sometimes Seldom Never

6. **How often do you fall back to sleep after being awakened in the morning?**

   Always Frequently Sometimes Seldom Never

7. **How often do you need someone to awaken you in the morning?**

   Always Frequently Sometimes Seldom Never

8. **How often do you think you need more sleep?**

   Always Frequently Sometimes Seldom Never

Office use only:

Scoring	4	3	2	1	0

*** Reverse score this item**

Abnormal Values: 6th & 7th Grade > 26, 8th Grade > 30

Parent/Guardian Initial_____

Office Use only:

History of missing teeth:
Extractions:
Premature birth:
Hypermobility:

Discomfort Scale

These are discomfort scales. For each part of the body there are horizontal rows, one for the left and one for the right. Please report your average discomfort for the last 7 days by circling the rating from 0 to 10 which best reflects your discomfort.

0 being no pain – 10 being unbearable pain

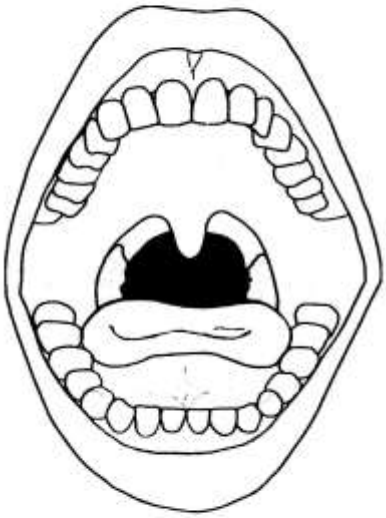
Bite symptoms or bite changes	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
TMJ joint pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
TMJ joint sounds	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Headaches	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Facial pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Eye symptoms	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Ear pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Stuffy ears or ringing sounds	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Neck pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Arm/hand/finger (numbness, tingling or pain)	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Upper back pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Lower back pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Pain in shoulder	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Pain on raising shoulder	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Difficulty raising shoulder	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10

Other Questions – please tick & answer in space provided			
Have you suffered trauma? Where? Age when it happened -	YES □ NO □	Have you been involved in an accident? Age when it happened -	YES □ NO □
Have you had surgery? Where? When?	YES □ NO □	Do you have trouble swallowing? When?	YES □ NO □
Have you experienced Vertigo? (dizziness, head spins) When?	YES □ NO □	Do you grind or clench your teeth? When?	YES □ NO □

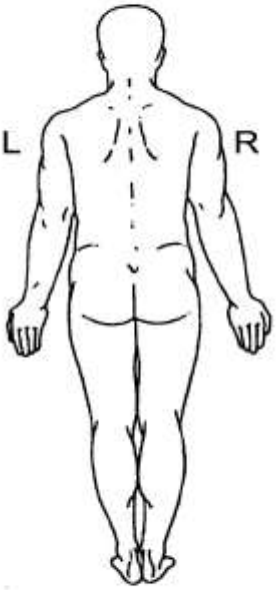
INITIAL _____

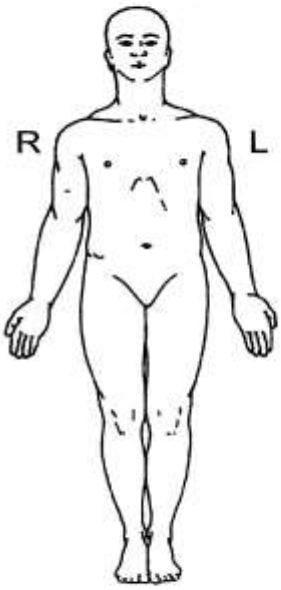
PAIN DRAWING

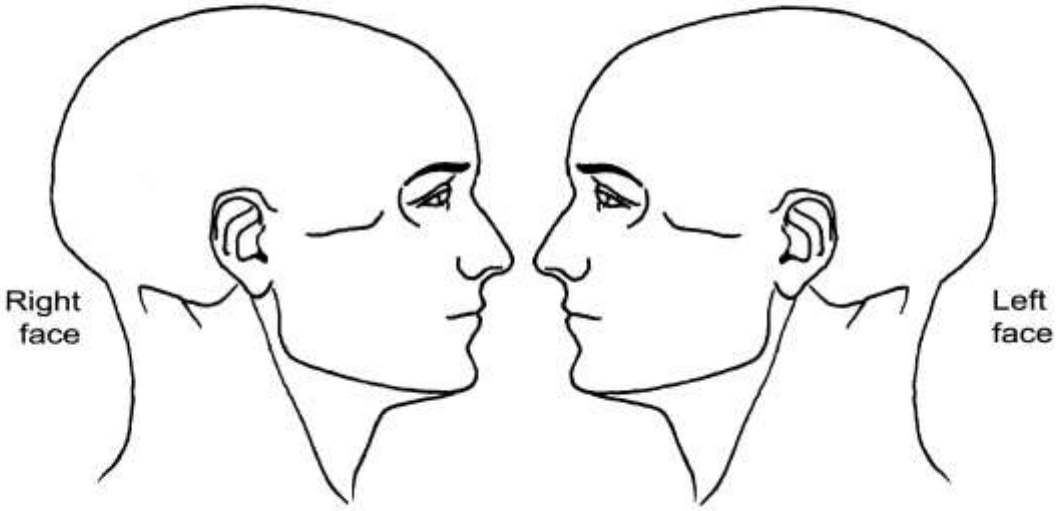
Indicate the location of ALL of your different pains by shading in the area, using the diagrams that are most relevant. If there is an exact spot where the pain is located, indicate with a solid dot (•). If your pain moves from one location to another, use arrows to show the path.



Mouth and teeth







Initial_____