MEDICAL & DENTAL HISTORY - CHILD (UNDER 16 YEARS)

CONFIDENTIAL

Last Name:	Title:
First Names:	DOB:
Who recommended this practice to you? ☐ Facebook ☐ Google ☐ Newspaper ☐ Dr _____ ☐ Friend ☐ Website ☐ Sign ☐ Yellow pages ☐ Other	
Residential Address:	
Suburb:	Postcode:
Mailing Address:	
Suburb:	Postcode:
Home Phone:	Mobile Phone:
Email:	Work Phone:
Emergency Contact name:	Mobile:
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? ☐ Yes ☐ No If yes, 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	

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

Chief complaint:

☐ I release and give my permission for this office to request information and communicate with other providers. I prefer my documents to be ☐ Emailed ☐ Posted ☐ Faxed	
Parent/Guardian Signature: *	Date: *

Disclaimer for Research Purposes: *Dr Karen McCloy has active research interests in both sleep disorders and facial pain. Your records may be de-identified and used for research purposes at some time.*

☐ *Please indicate by ticking the box if you do NOT consent for your records to be used.*

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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

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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 surgery	☐	Tendency to bleed longer than normal	☐	Hearing loss	☐
Heart valve disease	☐	Leukaemia	☐	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		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 nose	☐
Muscle weakness/Cramps	☐				
Cold Sores/Herpes	☐				

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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	☐
				Hepatitis or liver disease	☐
				Nausea/Vomiting	☐

Allergies:

TMD PAIN SCREENER

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. ☐ Pain comes and goes c. ☐ Pain is always present

2. In the last 30 days, have you had any 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

Paediatric Daytime Sleepiness Scale (PDSS)

Please answer the following questions as honestly as you can by selecting 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*

Scoring (Office use only)

4 *3* *2* *1* *0*

* Reverse score this item

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

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

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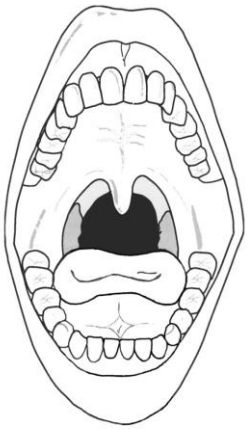
OTHER QUESTIONS – PLEASE TICK & ANSWER IN SPACE PROVIDED

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 ☐

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 & Teeth