NEWPORT CENTER
ORTHOTROPICS & ORTHODONTICS

Making a Difference in Children & Adult's Lives
With Facial Development & Airway Enhancement!

William B. Brady, D.D.S., M.S.
Orthotropic & Orthodontic Specialist

Medical Dental History Form for Patients Under Age 18

PATIENT

Date _____

Patient's last name _____ First name _____ Middle Initial _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ Sex ☐Male ☐Female Social Security # _____

School _____ Grade _____ Email address(es) _____

Home address _____ City, State, Zip code _____

Home phone ( ) _____ - _____ Cell phone ( ) _____ - _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with *(check all that apply)* ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Grandparent(s) ☐Other _____

Father's full name _____ Title: ☐Mr ☐Dr ☐Other _____

Occupation _____ Email address _____

Address *(if different)* _____

Home phone *(if different)* ( ) _____ - _____ Cell phone ( ) _____ - _____ Work phone ( ) _____ - _____

Mother's full name _____ Title: ☐Mrs ☐Ms ☐Dr ☐Other _____

Occupation _____ Email address _____

Address *(if different)* _____

Home Phone *(if different)* ( ) _____ - _____ Cell phone ( ) _____ - _____ Work phone ( ) _____ - _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

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Brother/sister name _____ age ____ had orthodontic treatment? ☐Yes ☐No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐Yes ☐No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐Yes ☐No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐Yes ☐No If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

Financial Responsibility

Who is financially responsible for this account? _____

Address *(if different than page 1)* _____ City, State, Zip _____

Home phone ( ) ____-____ Cell phone ( ) ____-____ Email address(es) _____

Social Security # _____ Employer _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

Dental Insurance

Primary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

Secondary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

Medical Insurance

Policy holder's full name _____

Insurance Company _____

Physician

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

Name _____ City, State _____

Reason _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no, or don't know/understand (dk/u).

Medical History

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Does your child eat a well-balanced diet?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Does your child frequently breathe through his/her mouth?
- ☐ ☐ ☐ Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐ ☐ ☐ Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

Has your child had allergies or reactions to any of the following?

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Plant pollens
- ☐ ☐ ☐ Animals
- ☐ ☐ ☐ Foods
- ☐ ☐ ☐ Other substances _____

Dental History

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Erupting teeth very early or very late?
- ☐ ☐ ☐ Primary (baby) teeth removed that were not loose?
- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Any lost or broken fillings?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ Frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ History of speech problems?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Has your child been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Has your child ever been diagnosed with gum disease or pyorrhea?

Patient Health Information

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

_____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does your child take antibiotic pre-medication before any dental procedures? _____

Does your child have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

Family Medical History

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

_____

How often does your child brush? _____ Floss? _____

Release and Waiver

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature _____ Date _____

Medical History Updates or Changes

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

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PEDIATRIC SLEEP QUESTIONNAIRE

Version 070424

Today's Date: _____

Name of Person Answering Questions: _____ **Relation to Child:** _____

Your Phone: (___) _____ **Your email Address:** _____

Child's Name: _____ **Age:** _____ **DOB** _____ **Sex:** (Circle) Male or Female

Grade in School (If Applicable): _____ **Current Ht.):** ____', ____". **Current Weight** (Pounds): _____

Racial/Ethnic Background of your Child (Please Circle):

1.) American Indian
2.) Asian-American
3.) African-American
4.) Hispanic
5.) White/not Hispanic
6.) Other or Unknown

Instructions:

Please answer the questions on the following pages regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general, not necessarily during the past few days, since these may not have been typical if your child has not been well.

If you are not sure how to answer any question, please feel free to ask your husband or wife, child, or physician for help. You should circle the correct response or *print* your answers neatly in the space provided. A "Y", means "yes", "N" means "no", and "DK" means "don't know". When you see the word "usually" it means "more than half the time" or "on more than half the nights."

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A. Nighttime and sleep behavior:		Office use only
WHILE SLEEPING, DOES YOUR CHILD ...		
... ever snore?	Y N DK	A1
... snore more than half the time?	Y N DK	A2
... always snore?	Y N DK	A3
... snore loudly?	Y N DK	A4
... have "heavy" or loud breathing?	Y N DK	A5
... have trouble breathing, or struggle to breathe?	Y N DK	A6
HAVE YOU EVER ...		
... seen your child stop breathing during the night? If so, please describe what has happened:	Y N DK	A7
... been concerned about your child's breathing during sleep?	Y N DK	A8
... had to shake your sleeping child to get him or her to breathe, or wake up and breathe?	Y N DK	A9
... seen your child wake up with a snorting sound?	Y N DK	A11
DOES YOUR CHILD ...		
... have restless sleep?	Y N DK	A12
... describe restlessness of the legs when in bed?	Y N DK	A13
... have "growing pains" (unexplained leg pains)?	Y N DK	A13a
... have "growing pains" that are worst in bed?	Y N DK	A13b
WHILE YOUR CHILD SLEEPS, HAVE YOU SEEN ...		
... brief kicks of one leg or both legs?	Y N DK	A14
... repeated kicks or jerks of the legs at regular intervals (i.e., about every 20 to 40 seconds)?	Y N DK	A14a
AT NIGHT, DOES YOUR CHILD USUALLY ...		
... become sweaty, or do the pajamas usually become wet with perspiration?	Y N DK	A15
... get out of bed (for any reason)?	Y N DK	A16

... get out of bed to urinate? If so, how many times each night, on average?	Y N DK _____ times	A17 A17a
Does your child usually sleep with the mouth open?	Y N DK	A21
Is your child's nose usually congested or "stuffed" at night?	Y N DK	A22
Do any allergies affect your child's ability to breathe through the nose?	Y N DK	A23
DOES YOUR CHILD ...		
... tend to breathe through the mouth during the day?	Y N DK	A24
... have a dry mouth on waking up in the morning?	Y N DK	A25
... complain of an upset stomach at night?	Y N DK	A27
... get a burning feeling in the throat at night?	Y N DK	A29
... grind his or her teeth at night?	Y N DK	A30
... occasionally wet the bed?	Y N DK	A32
Has your child ever walked during sleep ("sleep walking")?	Y N DK	A33
Have you ever heard your child talk during sleep ("sleep talking")?	Y N DK	A34
Does your child have nightmares once a week or more on average?	Y N DK	A35
Has your child ever woken up screaming during the night?	Y N DK	A36
Has your child ever been moving or behaving, at night, in a way that made you think your child was neither completely awake nor asleep? If so, please describe what has happened:	Y N DK	A37
Does your child have difficulty falling asleep at night?	Y N DK	A40
How long does it take your child to fall asleep at night? (a guess is O.K.)	_____ minutes	A41
At bedtime does your child usually have difficult "routines" or "rituals," argue a lot, or otherwise behave badly?	Y N DK	A42
DOES YOUR CHILD ... ... bang his or her head or rock his or her body when going to sleep?	Y N DK	A43
... wake up more than twice a night on average?	Y N DK	A44
... have trouble falling back asleep if he or she wakes up at night?	Y N DK	A45

... wake up early in the morning and have difficulty going back to sleep?	Y N DK	A46
Does the time at which your child goes to bed change a lot from day to day?	Y N DK	A47
Does the time at which your child gets up from bed change a lot from day to day?	Y N DK	A48
WHAT TIME DOES YOUR CHILD USUALLY ...		
... go to bed during the week?		A49
... go to bed on the weekend or vacation?		A50
... get out of bed on weekday mornings?		A51
... get out of bed on weekend or vacation mornings?		A52

B. Daytime behavior and other possible problems:		Office Use Only
DOES YOUR CHILD ...		
... wake up feeling unrefreshed in the morning?	Y N DK	B1
... have a problem with sleepiness during the day?	Y N DK	B2
... complain that he or she feels sleepy during the day?	Y N DK	B3
Has a teacher or other supervisor commented that your child appears sleepy during the day?	Y N DK	B4
Does your child usually take a nap during the day?	Y N DK	B5
Is it hard to wake your child up in the morning?	Y N DK	B6
Does your child wake up with headaches in the morning?	Y N DK	B7
Does your child get a headache at least once a month, on average?	Y N DK	B8
Did your child stop growing at a normal rate at any time since birth? If so, please describe what happened:	Y N DK	B9
Does your child still have tonsils? If not, when and why were they removed?:	Y N DK	B10
HAS YOUR CHILD EVER ...		
... had a condition causing difficulty with breathing?	Y N DK	B11

If so, please describe:		
... had surgery? If so, did any difficulties with breathing occur before, during, or after surgery?	Y N DK Y N DK	B12 B12a
... become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?	Y N DK	B13
... felt unable to move for a short period, in bed, though awake and able to look around?	Y N DK	B15
Has your child felt an irresistible urge to take a nap at times, forcing him or her to stop what he or she is doing in order to sleep?	Y N DK	B16
Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?	Y N DK	B17
Does your child drink caffeinated beverages on a typical day (cola, tea, coffee)? If so, how many cups or cans per day?	Y N DK _____ cups	B18 B18a
Does your child use any recreational drugs? If so, which ones and how often?:	Y N DK	B19
Does your child use cigarettes, smokeless tobacco, snuff, or other tobacco products? If so, which ones and how often?:	Y N DK	B20
Is your child overweight? If so, at what age did this first develop?	Y N DK _____ years	B22 B22a
Has a doctor ever told you that your child has a high-arched palate (roof of the mouth)?	Y N DK	B23
Has your child ever taken Ritalin (methylphenidate) for behavioral problems?	Y N DK	B24
Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?	Y N DK	B25

C. Other Information

1. If you are currently at a clinic with your child to see a physician, what is the problem that brought you?

2. If your child has long-term medical problems, please list the three you think are most significant.

_____.

_____.

_____.

3. Please list any medications your child currently takes:

Medicine	Size (mg) or amount per dose	Taken when?
_____	_____	_____
Effect:	_____.	
_____	_____	_____
Effect:	_____.	
_____	_____	_____
Effect:	_____.	
_____	_____	_____
Effect:	_____.	

4. Please list any medication your child has taken in the past if the purpose of the medication was to improve his or her behavior, attention, or sleep:

Medicine	Size (mg) or amount per dose	Taken how often?	Dates Taken
_____	_____	_____	_____
Effect: _____			
_____	_____	_____	_____
Effect: _____			
_____	_____	_____	_____
Effect: _____			
_____	_____	_____	_____
Effect: _____			

5. Please list any sleep disorders diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

6. Please list any psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

7. Please list any sleep or behavior disorders diagnosed or suspected in *your child's* brothers, sisters, or parents:

Relative	Condition
_____	_____
_____	_____
_____	_____

D. Additional Comments:

Please use the space below to print any additional comments you feel are important. Please also use this space to describe details regarding any of the above questions.

Instructions:

Please indicate, by checking the appropriate box, how much each statement* applies to this child:

This child often...	Does not apply 0	Applies just a little 1	Applies quite a bit 2	Definitely applies most of the time 3
... does not seem to listen when spoken to directly.				
... has difficulty organizing tasks and activities.				
... is easily distracted by extraneous stimuli.				
... fidgets with hands or feet or squirms in seat.				
... is "on the go" or often acts as if "driven by a motor".				
... interrupts or intrudes on others (e.g., butts into conversations or games.				

* Derived from DSM-IV.

THANK YOU

EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never *doze or fall asleep* in a given situation, and 3 meaning there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

TOTAL SCORE _____

Name: _____

Date: _____

Revised 09/25/08