

# Jeffrey W. Vecere, D.M.D., M.S.D., P.A.

22 West Pacific Avenue – Cape May Court House, NJ 08210

N.J. Specialty Permit No. 3226

## MEDICAL HEALTH HISTORY CHILD

Patient Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_

Please check any of the following conditions which you may have or have had:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Trouble                | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Breathing Problems                                |
| <input type="checkbox"/> Heart Murmur                 | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Cough   |
| <input type="checkbox"/> Heart Surgery                | <input type="checkbox"/> Phobias                 | <input type="checkbox"/> Herpes or Cold Sores                              |
| <input type="checkbox"/> Chest Pains                  | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Ulcers  |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Difficulty Swallowing                             |
| <input type="checkbox"/> Low Blood Pressure           | <input type="checkbox"/> Prolonged Infection     | <input type="checkbox"/> Bone Disorders                                    |
| <input type="checkbox"/> Blood Transfusion            | <input type="checkbox"/> Prolonged Sickness      | <input type="checkbox"/> Tumors and Growths                                |
| <input type="checkbox"/> Prolonged Bleeding           | <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Rheumatism              | <input type="checkbox"/> Fainting Spells                                   |
| <input type="checkbox"/> Wear a Pacemaker             | <input type="checkbox"/> Thyroid Problems        | <input type="checkbox"/> Glaucoma  |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Frequent Indigestion                              |
| <input type="checkbox"/> AIDS or HIV Infection        | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Soreness/Swelling Under Jaw, Arms, etc.           |
| <input type="checkbox"/> Tonsillitis                  | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> History of eating disorder? (anorexia or bulimia) |
|   | <input type="checkbox"/> Asthma                  |  |

Date of Last Medical Examination \_\_\_\_\_

Family Physician \_\_\_\_\_

### **Please answer YES or NO to the following questions:**

Is the patient presently under a physician's care?  Yes  No

If YES, for what condition? \_\_\_\_\_

Are you pregnant?  Yes  No

Do you need antibiotic medication before you see your dentist?  Yes  No

Is the patient presently receiving any medication?  Yes  No

Has the patient ever had an unusual reaction to any drug such as penicillin or local anesthetics?  Yes  No

Was the patient absent from school more than 5 days last year?  Yes  No

Have the patient's tonsils or adenoids been removed?  Yes  No

Has the patient had major surgery?  Yes  No

If YES, for what condition? \_\_\_\_\_

Are there any other pertinent medical problems?  Yes  No

If YES, please describe \_\_\_\_\_

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**Please complete second side of form »**

# PATIENT DENTAL HISTORY

Date of last dental examination? \_\_\_\_\_

Has the patient received a severe blow to the teeth or jaws?  Yes  No

Does the patient have problems with sore or bleeding gums?  Yes  No

Does the patient brush his/her teeth conscientiously?  Yes  No

Does the patient have any of the following habits?

Thumb Sucking  Nail Biting  Snoring  Mouth Breathing

Grinds teeth during  night or  day  Clenches teeth during  night or  day

Does patient follow directions well?  Yes  No

Has the patient ever had speech therapy?  Yes  No

Who first noticed the need for orthodontic treatment? \_\_\_\_\_

Does the patient want his/her teeth straightened?  Yes  No

Are you aware that appointments may infringe on school time?  Yes  No

Please offer other comments that may be helpful \_\_\_\_\_

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Has the patient ever been treated for "TMJ/TMD" problems?  Yes  No

Has the patient ever had accident or trauma:  
 To the head?  To the neck?  To the face?

Has the patient had headaches in the temple area?  Yes  No Left \_\_\_\_\_ Right \_\_\_\_\_

Has the patient experienced sinus problems?  Yes  No Left \_\_\_\_\_ Right \_\_\_\_\_

Has the patient experienced a popping clicking and/or grating noise in the ears?  Yes  No Left \_\_\_\_\_ Right \_\_\_\_\_

Has the patient experienced chronic stiff neck?  Yes  No Left \_\_\_\_\_ Right \_\_\_\_\_

## GROWTH INFORMATION

At what age did the following members of your family show the greatest change in height:

Mother \_\_\_\_\_ Father \_\_\_\_\_ Brothers/Sisters \_\_\_\_\_ Patient \_\_\_\_\_  
Father's Present Height \_\_\_\_\_ Mother's Present Height \_\_\_\_\_

### FEMALE PATIENTS:

Has the patient started her monthly period?  Yes  No Date \_\_\_\_\_ Age \_\_\_\_\_

Has the patient shown other signs of pubertal growth  Yes  No

### MALE PATIENTS:

Has the patient started to shave  Yes  No

Has the patient shown other signs of pubertal growth  Yes  No

Signature of Patient/Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Orthodontist \_\_\_\_\_ Date \_\_\_\_\_