Sparkle Dental Health History Form

So we can ensure we are looking after your child's needs, please review and complete the following questionnaire. If you require assistance to complete this form or would like written material provided to you in a language other than English, please advise our front office staff:

(Mst/Miss) Surname: Moore

First Name: Barker Preferred Name:

Address: 1 Armstrong street Suburb: Halls Head Postcode: 6210

Home Phone: 0439 356 059 Date of Birth: 24/10/2017

Mobile Phone:

Email: amypeat29@hotmail.com

Gender: ☑ Male ☐ Female

Name of person responsible for fees: Amy and Brendan Moore (parents)

Emergency contact person: Brendan Moore Ph Number: 0416 374 677

Referred to our practice by: Janna @ FunBe

Purpose of visit: to look into mouth breathing, oral airways, resting tongue posture and teeth/jaw developement.

Dental health insurance company: AHM.

Is another member of your family a patient at our practice: ☐ Yes ☑ No

Medical History

List any allergies your child has?

Severe dust allergies.

Does your child have asthma? ☐ Yes ☑ No

List any diagnosed conditions your child has?

List any medications your child is taking:

Nasonex nasal spray, Flixotide juniour (inhaler), Clarentyne antihistamine.

Name of GP/Medical Centre: Dr Karine Hay - Peel maternity and family practice

Phone Number: 9534 8133 Sholl Street, Mandurah.

Symptom Checker

There are many signs and symptoms about your child's health that you may not have known were connected with your child's teeth & health. By looking for and tracking these, we can get a better handle on the problem and watch for resolution.

Please tick any of the following that apply. If you're unsure, tick it anyway. Write comments if you want.

During the day, does your child:

- Breath with their mouth open? ☑
- Make noises when breathing? ☑
- Have trouble sitting still? ☐
- Attend speech pathology? being referred by school. ☑
- Have trouble chewing meat or other hard foods? ☑
- Frequently get tired? ☐

While sleeping, does your child:

- Have trouble going to sleep? ☑
- Have their mouth open? ☑
- Snore? Sometimes in the past. ☑
- Wet the bed? ☐
- Grind their teeth? ☐
- Toss & turn/kick the covers off? ☑
- Tilt their head back? Sometimes in the past ☑
- Have frequent nightmares/terrors? ☑
- Sweat at night? ☑
- Wake up frequently? ☑
- Have trouble waking up? ☐
- Have abnormal sleep issues? ☑

As of recently, wakes up and cries because cannot sleep.

History - Did your child ever:

- Use a dummy? If so, until what age? 3 ☑
- Suck their finger or thumb? If so, which? _____ ☐
- Have learning or attention problems? ☑
- Have trouble concentrating? ☑
- Have any behavioural concerns? ☑
  The school have raised concerns that he is not at the level he should be for age.

As a baby, was your child:

- Born premature? If so, how many weeks? 3 ☑
- Breast fed? If so, how many months? 6 weeks. ☐
- Hard to breast feed? ☑
- Refusing to chew food? When younger he would not chew properly. ☑
- Prone to ear infections? ☐
  Has not had any ear infections detected but has had inner ear pain and has scarring one one ear drum.

Did YOU ever have:

- Crooked teeth or braces? ☐
- Extractions for braces? ☐
- Allergies? ☑
- Asthma? ☐

* Barkers father had hay fever and now Barker has severe dust allergies, no others yet known.
* I myself as Barkers mother have only experienced allergies to cats.

How long since your child's last dental appointment? Never been to the dentist.

When were previous dental x-rays taken?: _____

Parent/Responsible party's signature: Amy Moore. Date: 12/9/2022

Relationship to patient: Mother.