MEDICAL HISTORY - CHILD

Name____________________________________

List any drug or medicine allergies_____________________________________________________
List drugs or medicine presently being taken____________________________________________
Is child under care of a physician now? Y    N    Reason________________________________
Has child ever been hospitalized?   Y    N     Reason____________________________________
Has child any history of/or difficulty with any of the following? If yes, explain

- Anemia____________________________________
- Hearing__________________________________
- Asthma___________________________________
- Heart____________________________________
- Bladder__________________________________
- Liver____________________________________
- Cerebral Palsy____________________________
- Malignancies_______________________________
- Chicken Pox_______________________________
- Thyroid__________________________________
- Rheumatic Fever__________________________
- Kidney___________________________________
- Chronic sinus______________________________
- Mastoid__________________________________
- Convulsions_______________________________
- Measles__________________________________
- Diabetes________________________________
- Mononucleosis_____________________________
- Epilepsy________________________________
- Mumps___________________________________
- Fainting________________________________
- Tuberculosis______________________________
- Other____________________________________

Is child presently experiencing a dental problem   Y    N  Explain____________________________
Date of last dental visit____________ For what services___________________________________

Please circle
Y    N   Has child had any unhappy dental experiences
Y    N   Any injuries to mouth, teeth or head
Y    N   Any mouth habits (thumbsucking, nail biting, mouth breather, bottle habits pacifier, etc.) please circle
Y    N   Any unusual speech habits? If yes, explain_______________________________________
Y    N   Orthodontic appliances worn now or ever
Y    N   Does your child brush his/her teeth daily
Y    N   Do you assist your child with tooth brushing
Y    N   Is dental floss used
Y    N   Is fluoride taken in any form  If yes, how______________________________

What is child’s favorite sport/hobby?______________________________________________________

Signature________________________________  Date___________________________

Reviewed:
Initial_______ Date_______ Initial_______ Date_______ Initial_______ Date_______