Your Child's Medical History

Your Child's Name _____ Nickname _____ Date _____

Birth Date _____ Patient Acct. No. _____ Medical Alert _____

Your Child's Physician: Name _____ Telephone _____

Address _____ City _____ State ___ Zip _____

Is your child under the care of a physician? ..... ❑ Yes ❑ No

If yes, please describe _____

Is your child taking any medications? (prescription or over-the-counter) ..... ❑ Yes ❑ No

If yes, please describe _____

Have you ever been told your child needs antibiotics or premeds before treatment? ..... ❑ Yes ❑ No

Does your child have any allergic (or adverse) reaction to any medication or other substance? ..... ❑ Yes ❑ No

If yes, please list _____

Are your child's immunizations current? ..... ❑ Yes ❑ No

List Any Hospitalizations, Surgeries, Serious Illnesses **When?**

_____ _____

_____ _____

_____ _____

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

AIDS/HIV positive	❑ Yes ❑ No	Congenital heart disease	❑ Yes ❑ No	Latex sensitivity	❑ Yes ❑ No
Allergies or Hives	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Lung problem	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Measles/Mumps	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Handicaps/Disabilities	❑ Yes ❑ No	Mononucleosis	❑ Yes ❑ No
Behavioral/Learning problem	❑ Yes ❑ No	Hay fever	❑ Yes ❑ No	Nervous disorders	❑ Yes ❑ No
Bleeding disorder	❑ Yes ❑ No	Hearing problem	❑ Yes ❑ No	Psychiatric/Psychological	❑ Yes ❑ No
Brain Injury	❑ Yes ❑ No	Heart condition	❑ Yes ❑ No	Rheumatic/Scarlet fever	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Heart murmur	❑ Yes ❑ No	Sickle cell anemia	❑ Yes ❑ No
Cerebral palsy	❑ Yes ❑ No	Hepatitis A B C (circle)	❑ Yes ❑ No	Stomach problem	❑ Yes ❑ No
Chicken pox	❑ Yes ❑ No	Kidney/Liver problem	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No

Other? ..... ❑ Yes ❑ No Please specify _____

_____

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Signature of Parent/Guardian _____ **Date** _____

Dentist's Review

Dentist's Signature _____ Date _____

Your Child's Dental History and Habits

Your Child's Name _____ **Nickname** _____ **Date** _____

Welcome! So that we may provide your child with the best possible care, please complete both sides of this dental/ medical history form. All information is completely confidential. Please be sure to answer individually any yes or no questions

What is the reason for your visit today? _____

_____

Your Child's Previous Dentist: Name _____ Telephone _____

Address _____ City _____ State ____ Zip _____

Date of your child's last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

How often does your child brush? _____ Floss? _____ Do you assist? ..... ❑ Yes ❑ No

Is your child's water fluoridated? ..... ❑ Yes ❑ No Does your child take fluoride supplements? ..... ❑ Yes ❑ No

Does your child have any dental problems now? ..... ❑ Yes ❑ No If yes, please describe _____

_____

How do you think your child will do? ..... ❑ Good ❑ Fair ❑ Poor

Has your child had difficulty with previous dental visits? ..... ❑ Yes ❑ No If yes, please describe _____

Has your child complained about dental problems? ..... ❑ Yes ❑ No If yes, please describe _____

Has your child ever worn orthodontic appliances? ..... ❑ Yes ❑ No If yes, please describe _____

Are any of your child's teeth sensitive to:

Hot or cold? ..... ❑ Yes ❑ No Sweets? ..... ❑ Yes ❑ No Biting or Chewing? ..... ❑ Yes ❑ No

Does your child engage in:

Sucking thumb or fingers? ..... ❑ Yes ❑ No
Biting or sucking lips or cheeks? ..... ❑ Yes ❑ No
Grinding teeth? ..... ❑ Yes ❑ No
Mouth breathing? ..... ❑ Yes ❑ No
Chewing or biting fingernails? ..... ❑ Yes ❑ No
Chewing hard objects (e.g., pencils)? ..... ❑ Yes ❑ No
Clenching jaw? ..... ❑ Yes ❑ No
Nursing bottle or pacifier habits? ..... ❑ Yes ❑ No

Do your child's gums bleed or hurt? ..... ❑ Yes ❑ No

Does your child have any pain or tenderness in the jaw joint, ear, side of face? ..... ❑ Yes ❑ No

Do you have any special concerns about your child's dental health? ❑ Yes ❑ No If yes, please describe _____

_____

_____