

Child's Medical History

Patient's Name: _____ **Birth Date:** _____

Is your child under a physician's care now? If yes, Explain _____ Yes No

Physician's Name: _____ Phone # _____

Date of last physical: _____ Results: _____

Is your child taking any medications, pills or drugs? If yes, please list all _____ Yes No

Has your child been hospitalized for any injury or surgery? If yes, explain _____ Yes No

Is your child up to date on all immunization? _____ Yes No

Girls: Is your child: Pregnant? Due Date: _____ Taking oral contraceptives? Nursing?

Is your child allergic to any of the following medication or substances? Aspirin Penicillin Metal
 Codeine Acrylic Latex Lidocaine Other: _____

Does your child now have or ever had any of the following?

AIDS	Yes	No	High blood pressure	Yes	No
Anemia	Yes	No	HIV+	Yes	No
Asthma	Yes	No	Jaundice	Yes	No
Bladder problems	Yes	No	Jaw pain	Yes	No
Bleeding problems	Yes	No	Kidney problems	Yes	No
Cancer	Yes	No	Liver problems	Yes	No
Cerebral palsy	Yes	No	Low Blood pressure	Yes	No
Chemotherapy	Yes	No	Measles	Yes	No
Diabetes	Yes	No	Mental disorder	Yes	No
Dizziness/Fainting	Yes	No	Nervous problems	Yes	No
Drug addiction	Yes	No	Pacemaker	Yes	No
Epilepsy	Yes	No	Psychiatric care	Yes	No
Excessive bleeding	Yes	No	Rheumatic/scarlet fever	Yes	No
Hay fever	Yes	No	Seizures	Yes	No
Head injuries	Yes	No	Shingles	Yes	No
Headaches	Yes	No	Sinus problems	Yes	No
Hearing problems	Yes	No	Stomach problems	Yes	No
Heart problems:	Yes	No	Thyroid disease	Yes	No
(please describe) _____			Tuberculosis	Yes	No
			Ulcers	Yes	No
Heart murmur	Yes	No	Other: _____		
If yes, does he/she need to be pre-medicated?	Yes	No	_____		
Hepatitis Type: _____	Yes	No	_____		

(please continue on the other side)

Dental History

What is your primary reason for this dental appointment? Examination Emergency

Consultation Other: _____

Does your child have a specific dental problem? Describe _____ Yes No

Did your child have dental examinations on a routine basis? Last visit: _____ Yes No

How many times a day does your child brush their teeth? _____

How many times a day does your child floss their teeth? _____

Is your child currently taking any form of fluoride supplement? _____ Yes No

Has your child complained about any dental problems? Describe _____ Yes No

Does your child grind or clench their teeth during the night? _____ Yes No

Does your child have any unhealthy mouth habits including thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.? _____ Yes No

Has your child have any injuries to mouth, teeth, neck or head? Describe _____ Yes No

Has your child lost any teeth? _____ Yes No

Has your child ever worn braces or an orthodontic appliance? _____ Yes No

Has your child had any unhappy dental experiences? Describe _____ Yes No

What is your child's attitude towards dentistry? _____

Does your child smoke or chew tobacco? _____ Yes No

Does your child have any sores or growths in their mouth? _____ Yes No

Name of your child's previous dentist: _____ Phone # _____

Date of last full mouth x-rays or pano: _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my child's health status or in their medications, I will inform the dentist and staff at the next appointment.

Parent/Guardian's Signature

Date