CHILD MEDICAL AND DENTAL HISTORY FORM

PATIENT'S NAME _____TODAY'S DATE: _____

DENTAL HISTORY – Please circle the appropriate answer and provide comments in the box provided.

1.Is this your child's first visit to a dentist? _____ YES NO
2.If not, how long since the last visit to the dentist? _____
3.Were any x-rays taken when your child previously visited the dentist? _____ YES NO
4.Does your child eat between meals? _____ YES NO
5.Does your child eat sweets such as candy, soda, and chewing gum in excess? __ YES NO
6.When does your child brush his/her teeth?
__ Morning __ Morning, after breakfast __Right after meals/snacks __Before bed
7.How does your child receive Fluoride?
__Community water source (please list source _____) __ Well Water
__Fluoride drops or tablets __Fluoride rinse or gel __Treatments at dental office
8.Have any cavities been noted in the past? _____ YES NO
9.Were any teeth (baby or permanent) removed by extraction? _____ YES NO
10.Have there been any injuries to teeth, such as falls, blows, chips, etc? _____YES NO
If yes, please explain: _____
11. Has your child had any problem with dental treatment in the past? _____ YES NO
12. Has anyone in the family, including parents, had orthodontics? _____ YES NO
13. Has your child ever received a local anesthetic? _____YES NO
14. Has your child ever had occlusal sealants? _____ YES NO
15. Does your **child** think there is anything wrong with his/her teeth? _____ YES NO

COMMENTS

MEDICAL HISTORY – Please use the box provided for all explanations/comments.

1.Does your child have a health problem? _____ YES NO
2. Is your child under the care of a physician? _____ YES NO
If yes, name and phone # _____
3. Is your child receiving any medication? Please list in the box provided. _____ YES NO
4. Is your child allergic to penicillin, antibiotics or other drugs? Please list. _____ YES NO
5. Is your child allergic or sensitive to latex or metals? Please list. _____ YES NO
6. Does your child have other allergies? _____ YES NO
7. Has your child had any serious illness? _____ YES NO
When: _____ What: _____
8. Has your child ever had surgery? _____ YES NO
9. Does your child have a heart murmur? _____ YES NO
10. Is surgery contemplated for this? _____ YES NO
11. Does your child experience severe or prolonged bleeding? _____ YES NO
12. Does your child have AIDS or has he/she tested HIV Positive? _____ YES NO
13. Has your child tested positive for hepatitis? _____ YES NO
14. Is your child subject to nervous disorders? _____ YES NO
__ Fainting __ Seizures __ Dizziness __ Behavioral/Learning Problems
15. Does your child suffer from frequent headaches? _____ YES NO
16. Has your child had a history of any of the following (please circle): diabetes, heart Trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, Congenital birth defects, mental illness, eyesight problems, cancer, infections, speech Impairments, hearing loss?
17. Has your child ever had an illness or medical condition not listed above? _____ YES NO
Please explain: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPELTE AND ACCURATE.

PATIENT/GUARDIAN'S SIGNATURE _____ DATE: _____

DENTIST'S SIGNATURE _____ ___ DATE: _____