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.

COMMENTS

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

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: ________________________