CHILD DENTAL/MEDICAL HISTORY

PATIENT'S NAME____

Last First Initial Nickname Date of Birth

PARENT/GUARDIAN'S NAME________________________________

DENTAL HISTORY – Circle the appropriate answer

yes no 1. Is this your child's first visit to the dentist? If not, how long since the last dental visit? ___________

yes no 2. Were any x-rays or radiographs taken on your child at their previous dentist?

yes no 3. Does your child eat between meals?

yes no 4. Does your child eat sweets such as candy, soda pop, chewing gum?

yes no 5. Have any cavities been noted in the past?

yes no 6. Has your child had any problem with dental treatment in the past?

yes no 7. Has anyone in the family, including parents, had orthodontics?

yes no 8. Has your child ever received local anesthetic?

yes no 9. Has your child ever had sealants placed on the biting surfaces of his/her back teeth?

yes no 10. Does your child think there is anything wrong with his/her teeth?

yes no 11. Has your child ever had a problem with thumb or finger sucking?

yes no 12. Have their ever been any injuries to the teeth such as falls, blows, or chips, etc.? Please explain: ___

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yes no 13. Were any baby or permanent teeth removed by extraction? If yes, was it suggested that the space b maintained? Y/N Was an appliance placed? Y/N

yes no 14. Does your child's primary source of water come from a filtered source, i.e. bottled, reverse osmosis other home filtration system?

15. Does your child receive fluoride in any of the following: community water ___ well water _____ flouride drops or tablets ______ fluoride rinse or gel _____

16. When does your child brush his/her teeth? upon waking ________ after eating any food ____ righ after meals ________ before going to bed _____ Is there any regular flossing? Y/N

MEDICAL HISTORY

yes no 1. Does your child have a health problem? Please explain: ______________________________

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yes no 2. Is your child under the care of a physician? If yes, since when and why? ____________________

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yes no 3. Name of physician ________________________________ Phone # ____________________

yes no 4. Is your child receiving any prescription medication or over the counter drugs? Please list _________

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yes no 5. Is your child allergic to Penicillin or any other drugs? Please list ___________________________

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yes no 6. Does your child have any other allergies?

yes no 7. Has your child had any serious illness? When? _________ What? ___________________________

yes no 8. Has your child ever had surgery?

yes no 9. Does your child have a heart murmur or other heart problems?

yes no 10. Does your child experience severe or prolonged bleeding?

yes no 11. Does your child have any behavioral/learning problems?

yes no 12. Does your child have a history of: (Circle appropriate responses) diabetes, asthma, kidney infection other kidney problems, rheumatic fever, epilepsy, cerebral palsy, live problems, congenital birth defe mental retardation, vision problems, cancer, frequent infections, AIDS/HIV positive, hepatitis, speech impairments, hearing loss, or being placed on a ventilator.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Parent's/Guardian's Signature ________________________________ Date ________________