CHILD DENTAL/MEDICAL HISTORY

Patient Name_____
Last First Initial Date of Birth

Parent's/Guardian's Name _____

DENTAL HISTORY–Circle the appropriate answer

Yes No 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?
Yes No 3. Were any x-rays or radiographs 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 pop, chewing gum?
6. When does your child brush his/her teeth?
____Upon arising____After eating any food____Right after meals____Before going to bed
Yes No 7. Have any cavities been noted in the past?
Yes No 8. Were any teeth (baby or permanent) removed by extraction?
Yes No 9. Have there been any injuries to teeth such as falls, blows, chips, etc.?
If so describe_____
10. Does your child have any jaw problems?
____Clicking or popping of jaw____Pain (joint, ear, side of face)____ Difficulty chewing
____Difficulty opening or closing____ Clenching or grinding
Yes No 11. Has your child had any problem with dental treatment in the past?
Yes No 12. Has any one 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 sealants?
Yes No 15. Does your child have a thumb habit?
Yes No 16. Does your child think there is anything wrong with his/her teeth?

MEDICAL HISTORY

Yes No 1. Does your child have a health problem?

Yes No 2. Is your child under care of a physician?
If yes, since when and why?_____
3. Name of Physician/Phone
_____
Yes No 4. Is your child receiving any medication?
What? _____
Yes No 5. Is your child allergic to penicillin, antibiotics, or other drugs?
Yes No 6. Does your child have 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?
Yes No 10. Does your child experience severe or prolonged bleeding?
Yes No 11. Does your child have AIDS or has he/she tested HIV positive?
Yes No 12. Has your child tested positive for hepatitis?
Yes No 13. Is your child subject to nervous disorders?
____Fainting?____Seizures?____Dizziness?____Behavioral/learning disability?
Yes No 14. Does your child have frequent headaches?
15. Has your child had history of:

___Heart trouble	___Rheumatic Fever	___Eyesight Problems
___Diabetes	___Cerebral Palsy	___Cancer
___Asthma	___Liver Problems	___Ear Infections
___Kidney Infection	___Congenital Birth Defects	___Speech Impairments
___Epilepsy	___Mental retardation	___Hearing Loss

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Parent's/Guardian's Signature_____Date_____