CHILD DENTAL/MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____

DENTAL HISTORY	
Is this your child's first visit to a dentist? If not, how long since the last visit?	
Were any x-rays or radiographs taken when your child previously visited the dentist?	Yes or No
Does your child eat sweets such as candy, soda pop, chewing gum?	Yes or No
When does your child brush his/her teeth? After eating any food? Right after meals? Before bed? Upon arising?	
How does your child receive Fluoride? Community water? Well water? Fluoride rinse or gel? Fluoride tablets or drops?	
Have any cavities been noted in the past?	Yes or No
Were any teeth (baby or permanent) removed by extraction?	Yes or No
Has there been any injuries to teeth, such as falls, blows, chips, etc.? If so, describe.	Yes or No
Has your child had any problems with dental treatment in the past?	Yes or No
Has anyone in the family, including parents, had orthodontics?	Yes or No
Has your child ever received a local anesthetic?	Yes or No
Has your child ever had occlusal sealants?	Yes or No
Does your child think there is anything wrong with his/her teeth?	Yes or No
MEDICAL HISTORY	
Does your child have a health problem?	Yes or No
Is your child under care of physician? If so, since when and why? Name of Physician is:	Yes or No
Is your child receiving any medication? If so, what?	Yes or No
Is your child allergic to penicillin, antibiotics or other drugs?	Yes or No
Is your child allergic to or sensitive to any metals or latex?	Yes or No
Does your child have any other allergies? Please list below:	Yes or No
Has your child had any serious illness? If so, when and what?	Yes or No
Has your child ever had surgery?	Yes or No
Does your child have a heart murmur?	Yes or No
Is surgery contemplated?	Yes or No
Does your child experience severe or prolonged bleeding?	Yes or No
Does your child have AIDS or has he/she tested HIV or hepatitis positive?	Yes or No
Is your child subject to nervous disorders? Fainting? Seizures? Dizziness? Behavior/learning problems?	Yes or No
Does your child have frequent headaches?	Yes or No
Has your child had history of: diabetes, heart trouble, asthma, kidney infection, Rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, cancer, infections, speech impairments, hearing loss, mental retardation, eyesight problems?	Yes or No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's/Guardian Signature _____ Date _____

Dentist's Signature _____ Date _____