Medical History

Today's Date_____

Childs Name:_____Preferred Name_____

Birth date_____ Age_____ Male / Female

Child's Physician_____Phone #_____

Clinic Name_____

Address_____City_____State_____Zip_____

Is your child currently under the care of a **Physician**? . . . . . .☐ YES ☐ NO

Please describe your child's current **physical health**. . . . . .☐ GOOD ☐ FAIR ☐ POOR

Does your child have any **mental or physical challenges** we should be aware of?_____

_____

Has your child had a **physical exam** within the last year? . . . . . .☐ YES ☐ NO When?_____

Has your child received **emergency medical treatment** within the last six months? . . . . . .☐ YES ☐ NO

Reason_____

Does your child have a **heart condition** or heart murmur? . . . . . .☐ YES ☐ NO

If yes, please explain_____

Has your child had a **blood transfusion** or any clotting agents? . . . . . .☐ YES ☐ NO

If Yes, Date of blood transfusion_____Reason for blood Transfusion_____

Has your child ever been **hospitalized**? . . . . . .☐ YES ☐ NO

Date_____ Reason_____

Does your child or anyone in your family have a history of **complication from general anesthesia or sedation**? ☐ YES ☐ NO

If so what type of anesthesia?_____

Please list any **allergies** your child may have. (i.e. medicine, food, latex, hay fever etc) . . . . ☐ NONE_____

_____

Please list any **medications (including Herbal) your child is currently** taking. . . . . ☐ NONE_____

_____

_____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Sinus Problems
Y N Hay Fever
Y N Asthma
Y N Exposure to smoking
Y N RSV Respiratory Illness
Y N Frequent Bronchitis
Y N Tonsillitis
Y N Snoring
Y N Problems Swallowing
Y N Heart Ailment
Y N Heart Murmur
Y N Congenital Heart Defect

Y N Anemia or Blood Problems
Y N HIV+
Y N AIDS
Y N Hemophilia
Y N Hepatitis A — B — C (circle one)
Y N Abnormal Bleeding
Y N Blood Transfusion
Y N Rheumatic Fever
Y N Kidney/Liver Problems
Y N Ulcer or Colitis
Y N Diabetes
Y N Thyroid Disorders

Y N Eye Disorders
Y N Hearing Impairment
Y N Handicaps/Disabilities
Y N ADD — ADHD (circle one)
Y N Psychiatric Care/ Emotional Problems
Y N Convulsions/Epilepsy
Y N Taking MAO Inhibitors
Y N Extreme nervousness or apprehension
Y N Any Operations
Y N Any stays in a Hospital

Dental History

Today's Date_____

Parental Expectations

What is the **greatest concern** you have regarding your child's teeth?_____
Has your child had a **recent toothache**? . . . . . □ YES □ NO _____
Are you **anxious** about your child's dental care? . . . . . □ YES □ NO_____
Any changes in **eating or sleeping habits**? . . . . . □ YES □ NO_____

Past Dental Problems/Care

Has your child ever experienced a **serious injury to the teeth or mouth**? . . □ YES □ NO_____

_____

Previous Dental Care

Who was your child's **previous Dentist**?_____ Phone# _____Date Last Seen_____
Has your child ever experienced a **negative dental or medical experience**? . . . . . □ YES □ NO _____

If yes explain_____

Dental Oral Development

At what age did the **first baby tooth** erupt?_____ Permanent Tooth?_____
Does/did your child ever use a **pacifier or suck their thumb**? . . . . . □ YES □ NO
Does your child **snore while sleeping**? . . . . . □ YES □ NO
Have your child's **tonsils or adenoids been removed**? . . . . . □ YES □ NO
Does your child **grind their teeth**?. . . . . □ YES □ NO
Has your child ever had any **pain or tenderness in their jaw** joint (TMJ/TMD)? . . . □ YES □ NO_____

Fluoride Use

What is your child's main **source of water**? . . . □ Tap Water □ Bottled Water □ Filtration System (type)_____
Does your child take **fluoride vitamins or supplements**? . . . . . □ YES □ NO If yes, dosage_____

Oral Hygiene

How often are the **child's teeth brushed**_____ **Who brushes** the child's teeth?_____
Does the **child Floss**? . . . . . □ YES □ NO

Infant Feeding History

Was your **child breastfed**? . . . . . □ YES □ NO How Long?_____
Was your **child bottle fed**?. . . . . □ YES □ NO How Long?_____
Does/Did your child ever **sleep with their bottle or sippy cup**? . . . . . □ YES □ NO

Diet History

Does your **child drink juice** on a daily basis? . . . . . □ YES □ NO Juice. if yes **full strength** or **diluted** with water
Does your **child drink pop** on a daily basis? . . . . . □ YES □ NO
What is your **childs favorite candy**?_____

Homeopathy/Religious Practices

Do you have any **strong feelings about medicine or dentistry** that you would like us to be aware of?_____

_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature **Relationship to patient** **Date**