

CHILD'S MEDICAL HISTORY

PT. NAME _____ Birthdate _____ Today's date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. (CONFIDENTIAL)

Are you under a physician's care now? Y ___ N ___ If yes, name and Ph.# of physician _____

Have you ever had any serious illness or had a major operation? _____

Are you taking any medications, pills, or drugs? Y ___ N ___ Please list your medications _____

Do you use any tobacco products? _____ How frequent? _____ Past use? _____

WOMEN: Are you pregnant/trying to get pregnant? Y ___ N ___ Taking oral contraceptives? Y ___ N ___

Are you allergic to, or have you ever reacted adversely to:

___ Aspirin ___ Penicillin/Amoxicillin ___ Codeine ___ Latex ___ Metal ___ Local anesthetics ___ Acrylic
___ Sulfa drugs ___ Other _____

Do you have, or have you had, any of the following? (* Condition may require premedication)

- | | | |
|--|--|---|
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Mitral Valve Prolapse* |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Rheumatic Fever* |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Scarlet Fever* |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Intestinal Disease |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Herpes | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> HIV positive/AIDS | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Other: _____ |

Do you have any disease, condition or problem not listed above that you think that I should know about? If so, please explain _____

Child's Dental History

CHILD'S NAME _____ Birth Date _____ Today's Date _____

1. How long since their last dental visit? _____
2. Is your child worried about dental visits? _____
3. If your child has had previous dental experiences, were they satisfactory? _____ If not, why? _____
4. Name and address of former dentist _____
5. Has your child had X-rays taken of their teeth? _____
6. Has your child had local anesthetic? _____ If yes, what was their reaction? _____
7. Has your child had nitrous oxide/oxygen for relief of anxiety? _____
8. Has your child had a history of decay or other dental problems? If yes, please explain _____
9. Is your water fluoridated or does your child use fluoride drops or tablets? _____
10. Does your child brush their own teeth? _____
11. What are your child's favorite snacks? _____
12. Is there any sensitivity in your child's mouth from hot, cold, sweets, or chewing? _____
13. Does your child have a history of thumb-sucking, nail biting, biting on hard objects, speech problems, clenching or grinding of teeth? _____ If yes, please explain _____
Have any corrective procedures been tried? _____
14. Has your child had any trauma or accidents involving the face and/or mouth? _____
15. Has your child had any teeth, other than the natural loss of baby teeth? _____
16. Are you satisfied with the appearance of your child's teeth? _____ Is your child satisfied? _____
17. Has orthodontic (braces) treatment ever been suggested for your child? _____
18. Please explain any other information which you feel would help us better treat your child _____

Parent's signature: _____ Date: _____

Dentist's Signature: _____ Date: _____