

welcome

Patients Name _____
Last First Initial Nickname Date of Birth

Parent's/Guardian's Name _____

COMMENTS

MEDICAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Does your child have a health problem?YES NO
2. Is your child under the care of a physician?YES NO
If yes, since when and why? _____
3. Name of physician _____
4. Is your child receiving any medications?YES NO
What? _____
5. Is your child allergic to penicillin, antibiotics, or any other drugs? .YES NO
6. Is your child allergic to or sensitive to any metals or latex?YES NO
7. Does your child have any allergies?YES NO
8. Has your child had any serious illnesses?YES NO
When _____ What _____
9. Has your child ever had surgery?YES NO
10. Does your child have a heart murmur?YES NO
(Does any of the following apply?)
Does patient have artificial heart valves? YES NO
Has patient ever had a history of infective endocarditis? YES NO
Was patient born with a certain specific, or serious congenital heart condition? .. YES NO
Has patient ever had a cardiac transplant? YES NO
11. Is surgery contemplated?YES NO
12. Does your child experience severe or prolonged bleeding?YES NO
13. Does your child have AIDS or has he/she tested HIV positive?YES NO
14. Has your child ever tested positive for hepatitis?YES NO
15. Is your child subject to nervous disorders?YES NO
 Fainting Seizures Dizziness Behavioral/Learning problems?
16. Does your child have frequent headaches?YES NO
17. Has your child had history of: (circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

Large empty rectangular box for handwritten comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTISTS SIGNATURE _____ DATE _____

CHILD DENTAL MEDICAL HISTORY

MED. ALERT box with empty space for marking.

welcome

Patients Name _____
Last First Initial Nickname Date of Birth

Parent's/Guardian's Name _____

COMMENTS

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

- 1. Is this your child's first visit to the dentist?YES NO
- 2. If not, how long since the last visit to the dentist? _____
- 3. Were any x-rays/radiographs taken when your child previously visited 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? YES NO
- 6. When does your child brush his/her teeth?
 Upon Arising After Eating Any Food Right After Meals Before going to bed
- 7. How does your child receive Fluoride?
 City Water Well Water Fluoride drops or tablets Fluoride rinse or gel
- 8. Have any cavities been noticed in the past?YES NO
- 9. Were any teeth (baby or permanent) removed by extraction?YES NO
 Was it suggested that the space be maintained?YES NO
 Was an appliance placed?YES NO
- 10. Have there been any injuries to teeth, such as falls, blows, chip, etc?YES NO
 If so, describe _____
- 11. Has your child had any problem with dental treatment in the past? ...YES NO
- 12. Has anyone 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 occlusal sealants?YES NO
- 15. Does your child think there is anything wrong with his/her teeth? ...YES NO

Large empty rectangular box for comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTISTS SIGNATURE _____ DATE _____

CHILD DENTAL MEDICAL HISTORY

MED. ALERT box