

# Medical History

**NAME OF CHILD** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Name of Child's Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

Date / reason for last visit \_\_\_\_\_

Are vaccinations current  yes  no

## Allergies / Adverse drug reactions

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**Does your child have an allergy to Latex ?** yes no

**Current medications** \_\_\_\_\_

**Previous medications** \_\_\_\_\_

Is your child in good health?..... yes no

Any difficulties with pregnancy or birth?..... yes no

Does your child have any special needs?..... yes no

If yes, explain \_\_\_\_\_

Has your child ever been hospitalized / had an emergency room visit? yes no

If yes, explain \_\_\_\_\_

Has your child ever had general anesthesia or sedation?..... yes no

If yes, explain \_\_\_\_\_

Has your child ever had problems with or been treated by a doctor for:

Heart / heart murmur yes no Eyes yes no

Artificial valve / joint yes no Speech / hearing yes no

Rheumatic fever yes no Tonsils / adenoids yes no

Birth defects yes no Liver / GI yes no

Seizures / Epilepsy yes no Diabetes/Endocrine yes no

Cancer/tumors yes no Hepatitis yes no

Headaches yes no AIDS or HIV+ yes no

Arthritis yes no TB /lung disease yes no

Learning problems yes no Bleeding/Hemophilia yes no

Behavioral problems yes no Blood transfusion yes no

Mental disorders yes no Anemia yes no

Autism yes no Asthma yes no

Down Syndrome yes no Skin yes no

Mentally Challenged yes no Cleft lip/ palate yes no

Hives or Rashes yes no Arthritis yes no

Genetic abnormality yes no Pregnancy yes no

Drug /alcohol addiction yes no Use tobacco products yes no

Other: \_\_\_\_\_

If female, age of first menstrual period \_\_\_\_\_

Do you consider your child to be: advanced progressing normal slow learner

Is there any other information about your child we should know?

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# Dental History

**NAME OF CHILD** \_\_\_\_\_

What is your major dental concern about your child? \_\_\_\_\_

Name of previous Dentist \_\_\_\_\_

Date of last dental x-rays \_\_\_\_\_

Reason for leaving former dentist \_\_\_\_\_

Has your child experienced an unusual reaction to dental medications or anesthetic?  
\_\_\_\_\_

Has your child had any prolonged bleeding or complications after dental treatments?  
\_\_\_\_\_

Does your child complain of any of the following? (Please check)

- |  |  |                                      |                                       |
|--|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Toothaches          | <input type="checkbox"/> Dental abscess  | <input type="checkbox"/> Sensitivity | <input type="checkbox"/> Gum bleeding |
| <input type="checkbox"/> TMJ pain or popping | <input type="checkbox"/> Mouth ulcers    |                                      |                                       |
| <input type="checkbox"/> Cavities            | <input type="checkbox"/> Facial Swelling |                                      |                                       |

Please check all forms of fluoride your child has exposure to:

toothpaste  rinses  supplements  other \_\_\_\_\_

Is there fluoride in your drinking water? yes no unknown

What beverages does your child drink? \_\_\_\_\_

How many times a day is your child's teeth brushed? \_\_\_\_\_ who brushes \_\_\_\_\_

Has your child had an injury to the teeth, jaws, or face \_\_\_\_\_

Are you unhappy with the appearance of your child's teeth?  
\_\_\_\_\_

Was your child bottle or breast fed? At what age was this stopped? \_\_\_\_\_

Has your child sucked fingers, thumbs, or a pacifier? \_\_\_\_\_

Has your child inherited any family dental characteristics? Please explain  
\_\_\_\_\_  
\_\_\_\_\_

Do you think your child will cooperate for dental treatment? \_\_\_\_\_

Has your child ever had nitrous oxide sedation general anesthesia please explain \_\_\_\_\_

Are you aware some children may cry, yell, or move around during dental treatment?  
\_\_\_\_\_ if so do you have any concerns or questions about this?  
\_\_\_\_\_  
\_\_\_\_\_

Please make note of any other dental concerns or complaints.  
\_\_\_\_\_  
\_\_\_\_\_