Child Health/Dental History

Patient's Name:_____ Date of Birth_____ Sex: M☐ F☐
Parents/Guardian's Name:_____ Relationship to Patient:_____

Child's Medical History

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cerebral Palsy	☐ Growth Problems	☐ Latex Allergy	☐ Seizures
☐ Arthritis	☐ Chicken Pox	☐ Hearing	☐ Liver	☐ Sickle Cell
☐ Asthma	☐ Chronic Sinusitis	☐ Heart	☐ Measles	☐ Thyroid
☐ Bladder	☐ Diabetes	☐ Hepatitis	☐ Mononucleosis	☐ Tobacco/Drug Use
☐Bleeding Disorders	☐ Ear Arches	☐ HIV+/AIDS	☐ Mumps	☐ Tuberculosis
☐Bones/Joints	☐ Epilepsy	☐ Immunizations	☐ Pregnancy (teens)	☐ Other_____
☐ Cancer	☐ Fainting	☐ Kidney	☐ Rheumatic Fever	

Child's Physician:_____ Phone:_____

Child's Dental History

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ☐ Yes ☐ No
If yes, please describe: _____
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? ☐ Yes ☐ No
If yes, please describe: _____
3. Is the child allergic to anything else, such as certain foods? ☐Yes ☐ No
If yes, please describe: _____
4. How would you explain your child's eating habits?_____
5. Has your child ever been hospitalized? ☐ Yes ☐ No
If yes, please describe: _____
6. Has the child ever had a serious illness?☐ Yes ☐ No
If yes, please describe: _____
7. Does the child have a history of any other illnesses? ☐ Yes ☐ No
If yes, please describe: _____
8. Has the child ever received general anesthetic? ☐ Yes ☐ No
9. Does the child have any speech difficulties? ☐ Yes ☐ No
If yes, please describe: _____
10. Is the child physically, mentally, or emotionally impaired? ☐ Yes ☐ No
If yes, please describe: _____
11. Does the child experience excessive bleeding when cut? ☐ Yes ☐ No
12. Is the child being treated for any illnesses? ☐ Yes ☐ No
If yes, please describe: _____
13. Is this the child's first visit to the dentist? ☐ Yes ☐ No If not, date of last visit:_____
14. Has the child had any problems with dental treatment? ☐ Yes ☐ No
If yes, please describe: _____
15. Has the child ever had dental x-rays? ☐ Yes ☐ No If yes, date of last x-rays:_____
16. Has the child ever suffered any injuries to the mouth, head or teeth? ☐ Yes ☐ No
If yes, please describe: _____
17. Has the child had any problems with the eruption or shedding of baby teeth? ☐ Yes ☐ No
If yes, please describe: _____
18. Has the child had any orthodontic treatment? ☐ Yes ☐ No
If yes, please describe:_____
19. What type of water does the child drink?
☐ City Water ☐ Well Water ☐ Bottled Water ☐ Filtered Water
20. Does the child take fluoride supplements? ☐ Yes ☐ No If yes, what kind?_____
21. Is fluoride toothpaste used? ☐ Yes ☐ No How many times does the child brush per day?_____ When are the teeth brushed?_____
22. Does the child suck his/her thumb, fingers, or pacifier? ☐ Yes ☐ No If yes, which one: _____
23. Does the child participate in sports? ☐ Yes ☐ No If yes, which sport(s) _____

Note: Both doctor and parent are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent/Guardian Signature _____ Date_____