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PATIENT MEDICAL AND DENTAL HISTORY

Date_____

Child's Name_____ ( )M ( )F

Age_____Date of Birth _____

Reason for Visit: Exam____ Emergency____ Decay____ Orthodontics____ Other _____

MEDICAL:

Yes No

( ) ( ) 1. Is your child in good health?

( ) ( ) 2. Is your child under the care of a physician for other than routine care? If yes, please explain_____

_____

( ) ( ) 3. Does your child have any drug allergies? If yes, which ones _____

( ) ( ) 4. Is your child taking any medications at this time? Please list _____

( ) ( ) 5. Has your child ever been hospitalized or treated in an emergency room? When and for what reasons_

_____

( ) ( ) 6. Has your child ever had general anesthetic?

( ) ( ) 7. Does your child have, or had any physical, mental or emotional disorders? If yes, please explain____

_____

( ) ( ) 8. Have your child's tonsils and/or adenoids been removed?

( ) ( ) 9. Does your child breathe through the mouth? If yes, seldom or often _____

Please indicate if your child has been diagnosed with any of the following:

____Allergy to Penicillin	____HIV	____Cleft Palate
____Other Drug Allergy	____Diabetes	____Asthma
____Radiation Treatment	____Seizures	____Allergies to Food, Pollen
____Anemia	____Bleeding Disorder	____Liver Problems
____Rheumatic Fever	____Tuberculosis	____Malignancies
____Bone Disorder	____Endocrine Disorder	____Leukemia
____Mental Handicap	____Physical Handicap	____Speech Problem/Hearing

____Heart Ailment or Murmur. Type if known_____. Is child under the care of a cardiologist or special physician for the problem? If so, whom _____ _____

Please comment on any problems that were checked in the above areas. _____

Do you consider your child to be: ___advanced in the learning process ___progressing normally ___a slow learner.

DENTAL:

Yes No

( ) ( ) Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child?

_____

( ) ( ) Do you expect your child to be a cooperative patient? If no, please explain_____

( ) ( ) Do you have well water at home?

( ) ( ) Does your child take fluoride tablets or drops or vitamins with fluoride?

( ) ( ) Has your child bumped any teeth? If so, when? _____

( ) ( ) Has your child a history of headaches, pain, popping or clicking of the jaws?

( ) ( ) Does your child take a bottle? When? If not, what age were they off? _____

( ) ( ) Does your child have a toothache?

( ) ( ) Does your child have or had any of the following habits?

____Thumb sucking How Long?_____Still active? _____

____ Finger sucking How Long?_____Still active? _____

____Pacifier How Long?_____Still active? _____

I give my consent to needed dental services, local anesthetic, oral medications and use of proper and acceptable methods for rendering dental care for _____. (Child's Name)

Signed_____(Parent or Legal Guardian)Date_____