Patient's Medical / Dental History

Patient's Name _____ Nick Name _____ Date _____

Birth Date _____ Sex _____ Place of Birth (City, State) _____

Parent / Responsible Party Home Phone _____ Work Phone _____

Name of School, Day Care or Babysitter _____ Grade _____

Favorite toy or pastime _____

Name and address of child's previous dentist _____ Phone _____

Last dental exam _____ Last dental XRAY _____

Name of child's physician or pediatrician _____ Phone _____

Last medical exam _____ Referred by _____

Chief Complaint / reason for visit _____

General condition of child's health _____

Has your child ever had (Check if yes)

- ☐ Accidents or Severe Infections
- ☐ ADD, ADHD
- ☐ Aids or Aids Related Symptoms, HIV+
- ☐ Anemia or Blood Disorders
- ☐ Asthma or Lung Problems
- ☐ Autism
- ☐ Behavior, Learning Problems
- ☐ Bleeding Problems
- ☐ Blood Transfusions
- ☐ Breathing, Lung Asthma
- ☐ Cerebral Palsy
- ☐ Congenital Birth Defects
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Endocrine System
- ☐ Enlarged Tonsils
- ☐ Headaches
- ☐ Heart Murmur, Congenital Heart Disease
- ☐ Heart trouble, Rheumatic Fever
- ☐ Intellectual Disability
- ☐ Kidney or Bladder Problems
- ☐ Liver, Hepatitis, GI Problems
- ☐ Mental Developmental Delays
- ☐ Neurological Problems
- ☐ Physical Developmental Delays
- ☐ Significant Injuries
- ☐ Skin Disorder
- ☐ Snoring, Sleep Apnea
- ☐ Speech, learning or hearing disorder
- ☐ Tumors, Cancer / Malignancies
- ☐ Tuberculosis
- ☐ Vision Problems

Please describe any current medical treatment including; drugs pending surgery, recent injuries or any other information the Dentist should be aware of or that has not been covered above.

_____

***PLEASE LIST ANY ALLERGIES TO Medicines, Foods, Latex, Etc.** _____

Dental History

Why did you make this appointment? _____

_____

Is this your child's first visit to a dentist? Yes No

If not, how long since the last dental visit? _____

Child's previous dentist:

Name: _____

Address: _____

Approximate date of last dental X-Rays _____

Has your child ever had any unpleasant dental experience: Yes No

if so please explain: _____

Does your child have any of the following habits ? (indicate ages when occurred)

Bottle to bed at night or nap _____

What was in the bottle? _____

Use a pacifier? _____

Thumb or finger sucking _____

Lip sucking or biting _____

Mouth breathing _____

Grinds teeth _____

Does your child brush his / her own teeth? ---------- Yes No

How Frequently and when? _____

Do you brush your child's teeth? ---------- Yes No

How Frequently and when? _____

Has your child had fluoride in any of the following forms?

Fluoride tablets or in multiple vitamins ---------- Don't Know Yes No

Drinking water (community fluoridation) ---------- Don't Know Yes No

Topical application on teeth (please circle) Dentist applied, Home rinse, Home brush-on gel, School rinse

Toothpaste brand _____

Have your child's teeth ever been injured? ---------- Yes No

When? _____Which teeth? _____

Cause? _____Were the teeth treated? _____

If so describe treatment _____

Has your child ever had any hearing , sight , coordination or special schooling problems? ---------- Yes No

Explain _____

Please indicate any health problems not discussed above _____

Has your child ever had tonsils removed or tonsillectomy ---------- Date _____ yes No

Has your child ever had an history of abnormal bleeding ---------- Yes No

Explain _____

Has your child received any blood transfusions ---------- Yes No

Does any member of the family have any medical / dental problems ---------- Yes No

Explain _____

Was your child bottle – fed or breast – fed For how long (months, years) _____

Does any member of the family have any unusual dental problems or TMJ disorders ---------- Yes No

Explain _____

At what age did first tooth appear early late normal

Are you concerned about any special dental problems now ---------- Yes No

Explain _____

Is your child experiencing any dental pain or discomfort now ---------- Yes No

Explain _____

Please list any questions that you would like to have answered _____

_____

Name and birth dates of other children _____

_____

Does your child tend to complain of clicking, popping or crunching noises in his her ears while chewing --- Yes No

The signature of a parent or guardian affixed below authorizes the completion of all mutually agreed upon necessary dental services.

Signature _____ Relationship _____ Date _____

Summary: (for Doctor's use) Reviewer: _____ Date: _____

Medical
Dental