CHILD DENTAL/MEDICAL HISTORY

Patient's Name _____
Last First Initial DOB

Parent's/Guardian's Name _____

Dental History – Circle the appropriate answer

1.	Is this your child's first dental visit?	YES	NO
2.	If not, how long since the last visit to the dentist?		
3.	Were any x-rays taken when your child previously visited the dentist?	YES	NO
4.	Does your child eat between meals?	YES	NO
5.	Does you child eat sweets, such as candy, soda pop, chewing gum?	YES.	NO
6.	When does your child brush his/her teeth?		
7.	How does your child receive fluoride? ☐Community water F- level ___ppm ☐well water ☐fluoride drops or tablets ☐fluoride rinse or gel ☐toothpaste		
8.	Have any cavities been noted in the past?	YES	NO
9.	Were any teeth (baby or permanent) removed by extraction? Was it suggested that the space be maintained? Was an appliance placed?	YES YES YES	NO NO NO
10.	Have there been any injuries to teeth, such as falls, blows, chips, etc?	YES	NO
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 that anything is wrong with his/her teeth	YES	NO
Medical History			
1.	Does your child have a health problem?	YES	NO
2.	Is your child under the care of a physician? When: Why:	YES	NO
3.	Name of physician Phone: ( )		
4.	Is your child receiving any medication? Please list in comments area	YES	NO
5.	Is your child allergic to penicillin, antibiotics or 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 illness? When: What:	YES	NO
9.	Has your child ever had surgery?	YES	NO
10.	Does your child have a heart murmur?	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 tested HIV positive?	YES	NO
14.	Is your child subject to nervous disorders? ☐Fainting ☐Seizures ☐Dizziness ☐Behavioral/Learning problems	YES	NO
15.	Does your child have frequent headaches?	YES	NO
16.	Has your child tested positive for hepatitis?	YES	NO
17.	Has your child had a history of: (Circle appropriate responses) diabetes, asthma, heart trouble, kidney function, rheumatic fever, epilepsy, cerebral palsy, cancer, liver problems, congenital birth defects, mental retardation, eyesight problems, infections, speech impairments, hearing loss.		

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE_____

DENTIST'S SIGNATURE _____ DATE _____

Patient's Name_____

Medical History Update #1

Date _____

Please review your medical history.

☐ There are no changes to my medical history ☐ There are changes to my medical history described below

_____

_____

_____

Patient's Signature_____ Doctor's Signature_____

Medical History Update #2

Date _____

Please review your medical history.

☐ There are no changes to my medical history ☐ There are changes to my medical history described below

_____

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_____

Patient's Signature_____ Doctor's Signature_____

Medical History Update #3

Date _____

Please review your medical history.

☐ There are no changes to my medical history ☐ There are changes to my medical history described below

_____

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_____

Patient's Signature_____ Doctor's Signature_____

Medical History Update #4

Date _____

Please review your medical history.

☐ There are no changes to my medical history ☐ There are changes to my medical history described below

_____

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_____

Patient's Signature_____ Doctor's Signature_____

Medical History Update #5

Date _____

Please review your medical history.

☐ There are no changes to my medical history ☐ There are changes to my medical history described below

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Patient's Signature_____ Doctor's Signature_____