Medical History

(Please fill out one history per child)

Child's Name: ____ Date of Birth: ______________________

Name of Child's Physician: ______________________________ Phone Number: ___________________

◯ Yes ◯ No Has your child ever been hospitalized or had surgery? If yes, please explain below

◯ Yes ◯ No Does your child have any medical conditions? If yes, please explain below

◯ Yes ◯ No Is your child taking any medications? If so, please list name, dosage and frequency.

◯ Yes ◯ No Does your child have any allergies to medications?

◯ Yes ◯ No Is your child allergic to anything else (i.e. gluten, dye, pets, latex, etc.)?

◯ Yes ◯ No Are your child's immunizations up to date?

Comments: ____

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Does your child have any of the following conditions?

◯ Anemia	◯ Asthma	◯ Autism	◯ Birth Defects	◯ Bleeding Problems
◯ Blood Disorders	◯ Blood Transfusions	◯ Cancer	◯ Cerebral Palsy	◯ Chronic Ear Infection
◯ Cystic Fibrosis	◯ Diabetes	◯ Down Syndrome	◯ Emotional Problems	◯ Epilepsy
◯ G-Tube Feeding	◯ Hearing loss	◯ Heart Condition	◯ Heart Murmur	◯ Hepatitis
◯ Herpes	◯ High Blood Pressure	◯ HIV/AIDS	◯ Hyperactivity/ADHD	◯ Intellectual Disability
◯ Kidney Disease	◯ Learning Disability	◯ Liver Disease	◯ Muscular Dystrophy	◯ Orthopedic plates
◯ Pregnant	◯ Psychiatric Problems	◯ Radiation Therapy	◯ Rheumatic Fever	◯ Seizures
◯ Sickle Cell Anemia	◯ Skin Disorder	◯ Sleep Apnea	◯ Snoring	◯ Speech Therapy
◯ Spina Bifida	◯ Tuberculosis	◯ Tumors	◯ X-ray treatment	◯ Other

Comments: ____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of parent/legal guardian: ____ Date: __________________

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Dental History

(Please fill out one history per child)

Child's Name: ___________________________________ Age: __________

Is this your child's first dental office experience? ◯ Yes ◯ No

If your child has previously seen a dentist:

Name of previous Dentist: ___________________________ Phone Number: _________________

Date of last visit: ______________________

Does the previous dentist have any X-rays? ◯ Yes ◯ No

Does your child do any of the following?

If your child has a history of any of these, please list the age it was discontinued.

◯ Bottle Use	◯ Currently	◯ Discontinued at age:________
◯ Nursing	◯ Currently	◯ Discontinued at age:________
◯ Pacifier Use	◯ Currently	◯ Discontinued at age:________
◯ Thumb/Finger Sucking	◯ Currently	◯ Discontinued at age:________
◯ Tongue Thrusting	◯ Currently	◯ Discontinued at age:________

Is your child currently experiencing any DENTAL PAIN? ◯ Yes ◯ No

If so, please describe: ____

How often are your child's teeth being brushed:

◯ Less than once a day
◯ Once a day
◯ Twice a day
◯ Three or more time a day

What toothpaste is your child using? ______________________________

Are your child's teeth being flossed? ◯ Yes ◯ No

If your child is using a mouth rinse, what rinse is it? __________________

Do you anticipate your child will be:

◯ Cooperative ◯ Uncooperative ◯ Unsure Comment:____________________________________

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Do you have any questions you would like answered by the dentist or staff today? __________________________

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