

PATIENT NUMBER

PATIENT'S NAME \_\_\_\_\_  
Last First Initial Nickname Date of Birth

PARENT'S/GUARDIAN'S NAME \_\_\_\_\_

**DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER**

**COMMENTS**

1. Is this your child's first visit to a dentist? ..... YES NO
2. If not, how long since the last visit to the dentist? \_\_\_\_\_
3. Were any x-rays or radiographs taken when your child previously visited the dentist? ..... YES NO
4. Does your child eat between meals? ..... YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
6. When does your child brush his/her teeth?  
 Upon arising  After eating any food  Right after meals  Before going to bed
7. How does your child receive Fluoride?  
 Community water level \_\_\_ ppm  Well water level \_\_\_ ppm  
 Fluoride drops or tablets  Fluoride rinse or gel
8. Have any cavities been noted in the past? ..... YES NO
9. Were any teeth (baby or permanent) removed by extraction? ..... YES NO  
Was it suggested that the space be maintained? ..... YES NO  
Was an appliance placed? ..... YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... YES NO  
If so describe \_\_\_\_\_
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 there is anything wrong with his/her teeth? ..... YES NO

**MEDICAL HISTORY**

1. Does your child have a health problem? ..... YES NO
2. Is your child under care of physician? ..... YES NO  
If yes, since when and why? \_\_\_\_\_
3. Name of physician \_\_\_\_\_ Phone \_\_\_\_\_
4. Is your child receiving any medication? ..... YES NO  
What? \_\_\_\_\_
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 other allergies? ..... YES NO
8. Has your child had any serious illness? ..... YES NO  
When \_\_\_\_\_ What \_\_\_\_\_
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 has he/she tested HIV positive? ..... YES NO
14. Has your child tested positive for hepatitis? ..... YES NO
15. Is your child subject to nervous disorders? ..... YES NO  
 Fainting?  Seizures?  Dizziness?  Behavioral/Learning problems?
16. Does your child have frequent headaches ..... YES NO
17. Has your child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

Large empty rectangular box for handwritten comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST. \_\_\_\_\_

MED. ALERT \_\_\_\_\_

# CHILD DENTAL MEDICAL HISTORY