

Patients Name _____ M__ F__ Date of Birth _____

MEDICAL HISTORY

Physicians Name _____ Date of Last Examination _____

Is your child seeing a physician now? __Y __N If so why? _____

Allergies _____

Allergies to medication _____

Does your child develop rash, hives, swelling or eye irritation after touching a balloon, rubber gloves, etc? __Y __N
Is your child currently taking any medications? __Y __N If yes please list medications _____

Does your child have or has your child ever had any of the following conditions?

Anemia	__Y __N __Unsure	Herpes	__Y __N __Unsure
Asthma	__Y __N __Unsure	High Blood Pressure	__Y __N __Unsure
Autism	__Y __N __Unsure	HIV—AIDS	__Y __N __Unsure
Birth Defects	__Y __N __Unsure	Hyperactivity	__Y __N __Unsure
Bleeding Problems	__Y __N __Unsure	Jaundice (not at birth)	__Y __N __Unsure
Blood Disorders	__Y __N __Unsure	Kidney Disease	__Y __N __Unsure
Blood Transfusions	__Y __N __Unsure	Learning Disabilities	__Y __N __Unsure
Cancer	__Y __N __Unsure	Liver Disease	__Y __N __Unsure
Cerebral Palsy	__Y __N __Unsure	Mental Retardation	__Y __N __Unsure
Chronic Ear Infections	__Y __N __Unsure	Muscular Dystrophy	__Y __N __Unsure
Cystic Fibrosis	__Y __N __Unsure	Pregnant (at this time)	__Y __N __Unsure
Delayed Speech Development	__Y __N __Unsure	Psychiatric Problems	__Y __N __Unsure
Developmental Delay	__Y __N __Unsure	Rheumatic Fever	__Y __N __Unsure
Diabetes	__Y __N __Unsure	Seizures	__Y __N __Unsure
Down Syndrome	__Y __N __Unsure	Sexually Transmitted Diseases	__Y __N __Unsure
Emotional Problems	__Y __N __Unsure	Sickle Cell Anemia	__Y __N __Unsure
Epilepsy	__Y __N __Unsure	Skin Disorders	__Y __N __Unsure
Fainting Spells	__Y __N __Unsure	Tuberculosis	__Y __N __Unsure
Hearing Loss/Impairment	__Y __N __Unsure	Tumors	__Y __N __Unsure
Heart Condition/Murmur	__Y __N __Unsure	X-ray Treatment (not dental)	__Y __N __Unsure
Hepatitis	__Y __N __Unsure		

Please explain all "Yes/Unsure" responses _____

Please list any other problems/conditions your child may have _____

DENTAL HISTORY

Is this your child's first visit to the dentist? __Y __N If no, date of last examination _____

Is this an emergency visit? __Y __N If your child is having a dental problem, please specify: _____

How do you think your child will react to this dental visit? __Cooperative __Uncooperative __Not Sure
If your child has seen a previous dentist, please list the name and phone number below:

Signature of Parent / Guardian _____ Date _____

Patient's Name _____

Date _____

To be Completed by a Parent or Guardian

Please circle the most accurate answer for each question

- | | | | |
|--|---------------------------------|-------------------------|-------------------------|
| 1. Number of times per day that child's teeth/gums are brushed/
cleaned | 0 | 1 | 2-3 |
| 2. Number of between-meals snacks or beverages consumed,
including juice, carbonated beverages and sports drinks (include
use of a bottle or sippy cup with liquid other than water and doses
of sweetened medicines) | More than
3 times
per day | 1-2
times
per day | Mealtimes
only |
| 3. Fluoride use, including local fluoridated water, vitamins
containing fluoride, fluoride supplements and toothpaste with
fluoride | None | Toothpaste
only | Toothpaste
and more |
| 4. If dental work was necessary, time since child last had a filling | Less than
1 year | 1-2 years | More than
2 years |
| 5. Child's parents or brothers/sisters have fillings or cavities | Yes | | No |
| 6. Child wears braces, oral appliances or space maintainers | Yes | | No |
| 7. How often does child routinely visit the dentist? | Less than
1 per year | 1 per year | More than
1 per year |
| 8. Child has special (physical or cognitive) needs that impact
cooperation or oral health care | Yes | | No |
| 9. Does anyone in your household smoke? | Yes | | No |

Parent/Guardian Signature _____

Date _____