

Child's Dental & Medical Health History Information

To the parents/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

PATIENT INFORMATION					
Last Name:	First Name:	Middle Name:	Nickname:		
Date of Birth: / /	Gender:				
Parent's/Guardian's Name:		Relationship to Patient:			
Email Address:					
Home Phone:	Cell Phone:	Work Phone:			
Mailing Address:	City:	State:	Zip:		
Please use an "X" to mark your answers to the following question.					
Have you (the adult) or the patient (the child) had? <input type="checkbox"/> A cough that's lasted longer than three weeks <input type="checkbox"/> A cough that produces blood <input type="checkbox"/> Active Tuberculosis					
Please bring this form to the receptionist right away if you marked "Yes" to any of these items.					
PATIENT'S DENTAL HEALTH HISTORY					
What is the reason for your visit today?					
How would you describe the patient's oral health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor					
Does the patient currently have any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____					
Is this the patient's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, when was the patient's last dental exam? _____ What was done at that appointment? _____					
When was the last time the patient had dental x-rays taken?					
Please use an "X" to mark your answers to the following questions.			Yes	No	?
Has the patient had any problem with dental treatment in the past?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe what happened: _____					
Has the patient had any problems with teeth coming in or losing teeth?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient use fluoride toothpaste when brushing teeth?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often are the patient's teeth brushed? _____ time(s) per _____ At what time(s) of day are the teeth brushed? _____					
Has the patient ever worn braces or other orthodontic appliances?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever had a serious injury to the head, mouth or teeth?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe what happened and when it happened: _____					
Does the patient play any contact sports or participate in active recreational activities?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe those activities here: _____					
Is your home water supply fluoridated?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What is the patient's primary source of drinking water? <input type="checkbox"/> Tap <input type="checkbox"/> Bottled <input type="checkbox"/> Filtered <input type="checkbox"/> Well					
Does the patient take fluoride supplements?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does/did the patient use a pacifier or suck his/her thumb or fingers?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At what age did the patient stop breastfeeding? _____ At what age did the patient stop bottle feeding? _____					
Has the patient ever experienced any sleep-related breathing disorders? <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep					

PATIENT'S MEDICAL HEALTH HISTORY & VACCINATION STATUS

Please list the name and phone number of the patient's physician:

Doctor's Name: _____ Phone: _____

Does the patient see any medical specialists? Yes No If yes, please explain. _____

Please use an "X" to mark your answers to the following questions. Yes No ?

Is the patient currently being treated for any condition(s) or illness(es)? If yes, what is the illness and when did it start?

Has the patient ever had a serious illness? If yes, what was the illness and when did it happen?

Has the patient ever been hospitalized? When and why?

Has the patient ever been given a general anesthetic?

Has the patient ever had a blood transfusion?

Does the patient experience excessive bleeding when cut?

Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist? If so, please explain why and provide the name of the doctor making that recommendation. Doctor's Name: _____ Phone: _____

Has the patient been diagnosed with any physical, developmental, mental or emotional conditions? If yes, please explain.

Does the patient have any genetic (inherited) conditions? If yes, please explain.

Does the patient have any speech difficulties? If yes, please explain.

How would you describe the patient's eating habits?

Is the patient up-to-date with immunizations related to childhood diseases (tetanus, measles, mumps, etc.)? Yes No

If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? Immunized Not immunized

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alcohol/Drugs | <input type="checkbox"/> Chronic sinusitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sexually transmitted infection (STI) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Thyroid issues |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Tobacco/Vaping |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Growth problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bone/Joint issues | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Mumps | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Issue | <input type="checkbox"/> Pregnancy (teens) | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | |

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions.

Yes No ?

Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications?
If yes, please list them here: _____

Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications?
If yes, please list those medications and what happened when the patient took them: _____

Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.?
If yes, please describe the allergy and the reaction: _____

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The dentist and I have talked about any questions I had about this form.

I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Parent/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only:

- Medical Alert Premedication Allergies Anesthesia

Reviewed by: _____ Date: _____