MEDICAL, DENTAL AND MEDICATION HISTORY

Child's Name: _____ What does your child like to be called: _____
(last name) (first name)

Date of birth: _____ Age: _____ Male / Female Grade Level: _____ School: _____

Child's Physician: _____ Approximate date of Last Physical Exam: _____

Child's Hobbies, Interests, Pets, etc.: _____

Siblings and their ages: _____

Reason for visiting our office today (circle one): Checkup Decay Habit Orthodontics Emergency Other: _____

YES NO Is your child under the care of a physician for other than routine care?
If yes, please explain: _____

YES NO Does your child have a history of infectious endocarditis (heart infection), congenital heart defect, or a history of heart surgery, i.e. artificial heart valves or heart transplant?
If so, circle one and explain: _____

YES NO Does your child have a prosthetic joint or brain shunt?
If so, circle one and explain: _____

YES NO Does your child have any drug allergies or has your child ever had a reaction to a drug?
If yes, please list the drug(s) and the reaction(s): _____

YES NO Does your child take any medication on a regular basis?
If yes, please list: _____

YES NO Is your child taking any medication at this time that he/she does not normally take on a regular basis?

YES NO If yes, please explain: _____

YES NO Has your child EVER been a patient in a hospital?

YES NO If yes, please explain: _____

YES NO Has your child EVER been in an emergency room for any reason?

YES NO If yes, please explain: _____

Please circle any condition your child currently has or has ever had:

Adrenal disorder	Ear/Eye disorder	Lung disorder	Mental Retardation	Cancer	Autism
Hearing problem	Allergy	Liver disease	Behavior problem	Tumor	Heart Murmur
Intestinal problem	Congenital Birth Defect	Muscle disorder	Speech problem	Epilepsy	Heart Surgery
Abnormal bleeding	Heart condition	Nose/Throat disorder	Kidney problem	Diabetes	LATEX ALLERGY
Blood disease	Endocrine problem	Recurrent Headaches	Physical Handicap	Hepatitis	
Bone disorder	HIV Positive	Blood transfusion	Stomach problem	Asthma	
Brain disorder	Learning difficulty	Skin disorder	Breathing problem	Seizures	

YES NO Has your child ever been seen by a pediatric dentist before? Approximate date of last visit? _____

YES NO Has your child ever been seen by a regular dentist before? Approximate date of last visit? _____

YES NO Do you expect your child to be uncooperative?

YES NO Does your child drink unfluoridated water?

YES NO Does your child take fluoride tablets, fluoride drops, or vitamins that contain fluoride?

YES NO Has your child ever bumped any teeth?
If yes, please explain: _____

YES NO Has your child ever experienced facial pain or had problem with the jaw joints near each ear?

YES NO Is your child a "toothpaste eater?"

YES NO Has your child had a traumatic medical or dental experience?
If yes, please explain: _____

YES NO Would you consider your child to be a slow learner?

YES NO Does your child suck his/her thumb, finger(s), pacifier, blanket, or something else? If yes, what: _____

YES NO Does your child have difficulty breathing through the nose with his/her mouth closed?

YES NO Is there anything else you would like to know or that we need to know about your child? If yes, please explain: _____

YES NO Young Children Only: Does your child have a bottle to go to sleep?

THE ABOVE MEDICAL, DENTAL AND MEDICATION HISTORY IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. IT IS MY RESPONSIBILITY TO NOTIFY CHILDREN'S DENTAL CENTER OF ANY CHANGE IN THE ABOVE INFORMATION PRIOR TO ANY APPOINTMENT.

Signed (Parent/Guardian): _____ Date: _____