Today's Date:_____

Health & Dental History

Child's Name: _____Age: _____ Birthdate:_____
Child's Gender: [ ] M [ ] F Height: _____ Weight: _____SSN:_____

Instructions:
Please answer all of the questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in the office. To the best of your ability honest answers must be given. If you are unsure of the question, please discuss the matter with the doctor. To properly evaluate your current health status, it may be necessary for the dentist to contact your physician. Included on this form is a section to certify that all information provided has been accurate, please sign in the presence of a member of the office staff.

Health & Dental
Child's Physician:_____ Physician's Telephone: _____

Name of Parent's Dentist: _____ Telephone: _____

Medical History

Please circle YES or NO below to indicate whether your child has ever had any of the following problems?

Y N Diabetes or other metabolic diseases
Y N Asthma
Y N Physical or Medical disabilities
Y N Seizures or recurrent headaches
Y N Behavioral or developmental disabilities
Y N Hives or skin rash
Y N Hepatitis, jaundice, or liver disease
Y N Arthritis (painful swollen joints)
Y N Stomach ulcers
Y N Kidney trouble
Y N Tuberculosis
Y N Sickle cell anemia
Y N High or low blood pressure
Y N Venereal disease
Y N HIV+/AIDS
Y N Mononucleosis
Y N Scarlet fever
Y N Measles
Y N Mumps
Y N Chicken Pox
Y N German measles
Y N 3-day or common measles
Y N Leukemia
Y N Fever of unknown origin

Y N Upper respiratory infection
Y N Ear infections
Y N Hearing impairment
Y N Vision problems
Y N Rheumatic fever
Y N Cerebral Palsy
Y N Brain injury
Y N Emotional disorder
Y N Heart condition
Y N Liver Problems
Y N Epilepsy
Y N History of abnormal bleeding
Y N Speech disorder
Y N Kidney problems
Y N Cancer, Tumors, or Blood Dyscrasias
Y N Hearing Disorder
Y N Retardation
Y N Nervous Disorder
Y N Lung problems
Y N Mental Disorder
Y N Serious injury that required hospitilization
Y N Blood Transfusion

Y N Are there any current medical problems being treated?
Y N Is your child currently taking any medications?
Y N Allergic reaction or serious side effect to any drug or medication?
Y N Has your child been advised to take antibotics prior to receiving dental treatment?
Y N Has your child ever been hospitalized or had surgery under general anesthesia?
Y N Do you consider your child to have any special needs?

Is your child allergic to any of the following drugs?

Y N Penicillin
Y N Asprin
Y N Erythromycin
Y N Acetominophen

Y N Tetracycline
Y N Dental Anesthetics
Y N Codine
Y N Ibuprofen

Y N Latex
Y N Other
Y N Sulfa
Y N Metals

Please describe any details associated with any questions that a "yes" was marked in the previous section or anything else you want us to know:_____
_____
_____
_____

Dental History

Y N Is this your child's first visit to the dentist?
If not, when was your child last seen by a dentist? _____
Y N Were any radiographs (x-rays) taken?

Why are you seeking treatment at this time? _____

Y N Has your child had a bad experience at the dentist?

Y N Has your child had any previous dental work done?
If yes, how was it completed? (please check one)
[ ] office visit
[ ] conscious sedation sedative drink
[ ] general anthesia hospital

Describe your child's behavioral response to past dental and medical care:_____

How do you think your child will do at today's visit? _____
_____

How do you think your child will do if they received standard dental treatment (a shot in the gums to numb the teeth?): _____
_____

Y N Does your child snore when sleeping?

Who usually does the brushing in your home? _____

Y N Is your child now taking a prescription fluoride supplement?

Y N Is your child a thumb/finger sucker?

Y N Does your child use a pacifier?

Y N Does your child use dental floss?

Y N Do your child's gums bleed upon brushing?

Y N Does your child complain about their teeth being sensitive?

Y N Are there any sores or growths in your child's mouth?

Y N Does your child complain on having a tooth ache?

Y N Has your child sustained any dental trauma?
If yes, describe: _____

I certify all statements on this form to be true.

Person completing this form? *(sign)* _____ Relation to patient? _____
Name of Staff Witness? *(sign)* _____ Date: _____

6 Month Exam Recall
Date: _____ Signature:_____