

Why did you bring the child to the dentist today? _____

Y N Has the child ever had a serious/difficult problem associated with previous dental visits?

Y N Is the child's water fluoridated?

Y N Is the child taking fluoridated supplements?

Y N Has the child ever had any pain / tenderness in his/her jaw joint (TMJ/TMD)?

Y N Does the child brush his/her teeth daily?

Y N Floss his/her teeth daily?

Child's Physician: _____

Phone#: _____

Date of last visit: _____

Y N Is the child currently under the care of a physician?

Please describe the child's physical health:

Good ___ Fair ___ Poor ___

Please list all drugs that the child is currently taking: _____

Please list all drugs that the child is allergic to: _____

Please discuss any serious medical problems that the child has had: _____

Does/did the child have any of the following habits?

Y N Lip Sucking/Biting

Y N Nail Biting

Y N Nursing Bottle Habits

Y N Thumb/Finger Sucking

Y N Was the child breast fed?

Has the child ever had any of the following medical problems?

Y N Abnormal Bleeding

Y N Allergies to any Drugs

Y N Anemia

Y N Any Hospital Stays

Y N Any Operations

Y N Asthma

Y N Cancer

Y N Chicken Pox

Y N Congenital Heart Defect

Y N Convulsions/Epilepsy

Y N Diabetes

Y N Exposed to HIV/but Neg.

Y N Handicaps/Disabilities

Y N Hearing Impairment

Y N Heart Murmur

Y N Hemophila

Y N Hepatitis

Y N Hives

Y N HIV/AIDS

Y N Immunizations Current

Y N Kidney/Liver Problems

Y N Measles

Y N Mononucleosis

Y N Rheumatic/Scarlet Fever

Y N Skin Rash

Y N Tuberculosis (TB)

Y N Anything you would like to discuss with the doctor in private?

I have reviewed the medical/dental information above with the parent/guardian and patient herein. _____ Initials _____ Date

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDC and the ADA

I understand that the information that I have given is correct to the best of my knowledge, that it will held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child my need.

Signature of parent or guardian

Date

OFFICE USE ONLY OFFICE USE ONLY

Medical History Update

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____