

CHILD'S MEDICAL HISTORY

Child's current physical health is: ___Good ___Fair ___Poor

Is child currently under the care of a physician? ___No ___Yes Last Medical Exam: ___/___/___

Please explain _____

Is child taking any prescription / over-the-counter drugs? ___No ___Yes

Please list each one: _____

Has your child had any of the following diseases or medical problems?

Y	N	Heart Attack / Stroke	Y	N	Psychiatric Problems
Y	N	Heart Murmur	Y	N	Epilepsy / Seizures / Fainting Spells
Y	N	Mitral Valve Prolapse	Y	N	Diabetes / Tuberculosis (TB)
Y	N	Rheumatic Fever	Y	N	Heart Surgery / Pacemaker
Y	N	Artificial Valves	Y	N	Hemophilia / Abnormal Bleeding
Y	N	Congenital Heart Defect	Y	N	Ulcers / Colitis
Y	N	High / Low Blood Pressure	Y	N	Cancer / Chemotherapy
Y	N	Kidney Problems	Y	N	Anemia / Radiation Treatment
Y	N	Artificial Bones / Joints	Y	N	Arthritis
Y	N	Asthma	Y	N	Glaucoma
Y	N	Difficulty Breathing	Y	N	HIV+ / AIDS
Y	N	Emphysema	Y	N	Hepatitis
Y	N	Sinus Problems	Y	N	Blood Transfusion
Y	N	Severe / Frequent Headaches	Y	N	Hospitalized for any reason

Is your child allergic to any of the following items?

Y	N	Penicillin	Y	N	Tetracycline
Y	N	Aspirin	Y	N	Dental Anesthetics
Y	N	Erythromycin	Y	N	Any Metal / Plastics
Y	N	Latex	Y	N	Codeine

Please list any other drugs that you are allergic to: _____

CHILD'S DENTAL HISTORY

What is your chief complaint regarding your child's teeth? _____

General Dentist: _____ Last Dental Visit: _____

Please indicate if any of the following pertain to your child:

- | | | | | | |
|---|---|---|---|---|--|
| Y | N | Pain in or near ears | Y | N | Sensitive Teeth |
| Y | N | Any unhealed injuries or inflamed areas
in or around mouth | Y | N | Food Impaction |
| Y | N | Any growth spots in mouth | Y | N | Burning tongue |
| Y | N | Discomfort in any part of mouth | Y | N | Unpleasant taste |
| Y | N | Has your child ever had any reaction to a
dental injection | Y | N | Unfavorable dental experience |
| Y | N | Any difficult extractions in the past | Y | N | Bad Breath |
| Y | N | Prolonged bleeding following extractions | Y | N | Mouth breathing |
| Y | N | Trench Mouth | Y | N | Oral Habits – fingernail biting,
cheek biting, etc. |
| Y | N | Does your child use dental floss | Y | N | Bleeding gums |
| Y | N | Has your child received instructions on the correct method of brushing her teeth. | Y | N | Does your child clench his teeth |

Y

Texture of tooth brush _____ Frequency of brushing _____time(s) per day

Y N Does your child chew only on one side of her mouth? If yes, why? _____

Y N Are you happy with your child's smile?
If no, explain _____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest 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 any necessary dental services for my child with my informed consent that he may need during diagnosis and treatment.

So that we maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees. Once you have made an appointment, remember this time is reserved for your child. Therefore, if you must cancel an appointment, please give us sufficient notice.

Signature: _____ Date: _____

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(FOR OFFICE USE)

I verbally reviewed the medical and dental information above with the patient named herein.

This patient _____ does / _____ does not require premedication prior to dental treatment.

Medication for Pre Med _____ Doctor's Initials _____ Date _____