It is important for us to know about your Medical and Dental History. These facts have a direct bearing on our Dental health. Thank you for taking the time to complete this questionair.

Patient Name _____ DOB: _____ Date _____

Dental Health

Why did you bring the child to the dentist today?

_____

_____

Is the Child's water fluoridated? ☐ Yes ☐ No ☐ Unknown
Is the Child taking fluoridated supplements? ☐ Yes ☐ No
Does the child brush his/her teeth daily? ☐ Yes ☐ No
Does the child floss his/her teeth daily? ☐ Yes ☐ No

Has the child ever had any pain/ tenderness in his/her jaw joint (TMJ/TMD) ? ☐ Yes ☐ No

Has a prior dentist recommended nitrous oxide or sedation to help with dental treatment ? ☐ Yes ☐ No

Does/ did the child experience any of the following:
Thumb/finger sucking ☐ Yes ☐ No
Lip sucking/biting? ☐ Yes ☐ No
Nail Biting? ☐ Yes ☐ No
Nursing bottle habits? ☐ Yes ☐ No
Was the child breast fed? ☐ Yes ☐ No

Please list all the drugs the child is currently taking:

_____

_____

Please list all the drugs/things that the child is allergic to:

_____

_____

Additionally, is the child allergic to:
Latex? ☐ Yes ☐ No
Metals/Nickel? ☐ Yes ☐ No
Plastic? ☐ Yes ☐ No

Is there anything you would like to discuss with the doctor in private?

_____

_____

Health History Update
Sig. _____ Date. _____
Sig. _____ Date. _____
Sig. _____ Date. _____

Medical History

Is the child currently under the care of a primary physician? ☐ Yes ☐ No

Physicians name: _____
Phone #: _____ Last Visit: _____
Please describe the child's current health:
☐ Good ☐ Fair ☐ Poor

Are the child's immunizations current?
☐ Yes ☐ No

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

Abnormal Bleeding	☐ Yes	☐ No
ADD/ADD	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Any Hospital Stays	☐ Yes	☐ No
Any Operations	☐ Yes	☐ No
Artificial Bones/Joints/Valves	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Autism	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Exposed to HIV, but Neg.	☐ Yes	☐ No
Hearing Impairment	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Hives	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Kidney/Liver Problems	☐ Yes	☐ No
Measles	☐ Yes	☐ No
Mononucleosis	☐ Yes	☐ No
Rheumatic/Scarlet Fever	☐ Yes	☐ No
Sickle Cell Disease/Traits	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No

Please describe any serious medical concerns that your child has had:

_____