

Medical/Dental History For Children

Name: _____ Date of birth: _____ Nick Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip code: _____

Physicians Name: _____ Physicians Phone Number: _____

Has your child ever been hospitalized? If so why? _____

Allergies _____ Allergies to medications _____

Is your child up to date with vaccinations? YES NO

Does your child develop rashes, hives, swelling or eye irritation after touching a balloon, rubber gloves, and etc.? YES NO

Is your child taking any medication? YES NO If so please list medication _____

Does your child have or ever had any of the following conditions?

(Please circle yes or no)

- | | | |
|-------------------------------|----------------------------|--|
| Yes No Anemia | Yes No Asthma | Yes No Birth Defects |
| Yes No Bleeding Problems | Yes No Blood Disorders | Yes No Blood Transfusions |
| Yes No Cancer | Yes No Cerebral Palsy | Yes No Chronic Ear Infections |
| Yes No Cystic Fibrosis | Yes No Delayed speech | Yes No Developmental Delays |
| Yes No Diabetes | Yes No Down's Syndrome | Yes No Emotional Problems |
| Yes No Epilepsy | Yes No Fainting Spells | Yes No Hearing Loss/Impairment |
| Yes No Heart Condition/Murmur | Yes No Hepatitis | Yes No Herpes |
| Yes No High Blood Pressure | Yes No Hyperactivity | Yes No Jaundice (Not at birth) |
| Yes No Kidney Disease | Yes No Learning Disability | Yes No Liver Disease |
| Yes No Mental Retardation | Yes No Muscular Dystrophy | Yes No Psychiatric Problems |
| Yes No Rheumatic Fever | Yes No Seizures | Yes No Sexually Transmitted Disease/AIDS |
| Yes No Sickle Cell Anemia | Yes No Skin Disorders | Yes No Trouble Sleeping |
| Yes No Snoring | Yes No Tuberculosis | Yes No Tumors |
| Yes No Thyroid | | |

Please list any other problems/conditions your child may have: _____

Was your child bottle or breast fed?.....If Yes, up to what age _____

Is this your child's first visit to the dentist?.....Yes No

If this is not the first visit, then when was the last exam?.....Yes No

Does your child snack between meals?Yes No

Does your child consume candy, soda, or gum?Yes No

How many times does your child brush his/her teeth? _____

How does your child receive fluoride? _____

Has your child had cavity before?Yes No

Has your child had any teeth extracted?Yes No

Has there been any teeth that have had any lesions or trauma?Yes No

Has your child had a bad experience at a dental office?Yes No

Has your child ever received local anesthetic?Yes No

Has your child had any sealants done?Yes No

Does your child think there is a problem with his/her teeth?Yes No

Does your child use a pacifier or have any oral habits like thumb/finger sucking.....Yes No

Does your child clench or grind their teeth?.....Yes No

List any comments: _____

I certify that all the information above is filled completely and exactly to the best of my knowledge.

Signature: _____