

## Child Medical & Dental History Form

TODAY'S DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
First Last Initial

PARENT OR GUARDIAN NAME \_\_\_\_\_  
First Last Initial

CIRCLE THE APPROPRIATE ANSWER

FOR OFFICE USE ONLY

**MEDICAL HISTORY**

1. Is the child in good health? ..... Y N
2. Is the child under the care of a physician? ..... Y N  
*If yes, why?* \_\_\_\_\_
3. Physician \_\_\_\_\_ Phone # \_\_\_\_\_
4. Is the child taking any medication? ..... Y N
5. Has the child had any serious illness? ..... Y N  
*If so, what and when?* \_\_\_\_\_
6. Is the child allergic to penicillin, antibiotics or any other drugs? ..... Y N
7. Does the child have any other allergies? ..... Y N
8. Has the child ever bled excessively from a cut or injury? ..... Y N
9. Is the child subject to nervous disorders, fainting or dizzy spells? ..... Y N
10. Has the child a history of diabetes, heart trouble, asthma, kidney infection or rheumatic fever? ..... Y N
11. Is there anything else we should know about the child's health? ..... Y N
12. *If so, what?* \_\_\_\_\_

**DENTAL HISTORY**

1. Is this the child's first visit to the dentist? ..... Y N  
*If not, how long since the last visit?* \_\_\_\_\_
2. When was the last time his/her teeth were cleaned? \_\_\_\_\_
3. Does the child eat sweets such as candy, soda pop, chewing gum? .... Y N
4. Does the child eat between meals? ..... Y N
5. Does the child brush teeth upon rising? ..... Y N  
     Before bed ..... Y N  
     After eating meals? ..... Y N  
     After eating snacks? ..... Y N
6. Do you live in an area with fluoridated water? ..... Y N
7. Have the teeth been treated with fluoride? ..... Y N
8. Has the child had protective sealants? ..... Y N
9. Were any teeth removed by extraction? ..... Y N
10. Have there been any injuries to the teeth, face or jaws? ..... Y N
11. Has the child had any unfavorable dental experiences? ..... Y N
12. Has the child ever had local anesthetic for dental treatment? ..... Y N
13. Do you have any preference for the type of fillings used? ..... Y N

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE**

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

DOCTOR SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_