

Child Medical & Dental History Form

TODAY'S DATE _____

PATIENT NAME _____ DATE OF BIRTH _____
First Last Initial dd/mm/yy

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: _____