

MEDICAL AND DENTAL HISTORY FORM

Patient Name: [Last] [First] [MI] [Preferred Name] Chart# [office use only]

Please take a moment to let us know about your child's medical and dental history so we may serve your child more effectively and in a way that watches out for his/her overall health and well-being.

MEDICAL HISTORY:

Would you consider your child to be in fairly good health? Yes No

What is the date (or approximate date) of your child's last medical exam? [MM/DD/YYYY]

Your child's Pediatrician or Primary Care Physician's name, address, & phone number:

Please indicate YES or No in response to the following questions:

- Yes No Within the past year, has there been any changes in your child's general health?
Yes No Does your child require antibiotic premedication before dental treatments (SBE prophylaxis)?
Yes No Has your child or family members ever had complications following a dental treatment, sedation, or general anesthesia?
Yes No Is your child currently under the care of a physician due to a specific condition?
Yes No Has your child ever been hospitalized due to a surgery or illness?
Yes No Does your child have snoring, obstructive sleep apnea, or mouth breathing?

If any of the previous questions are marked YES, please explain:

Is your child currently taking any prescription or non-prescription medications? Yes No

If YES, please list below, medication names, dosage, frequency taken, and what conditions they are taken for.

Please indicate if your child has experienced any of the following currently or in the past:

- Allergy - Asprin Arthritis Dizziness High Blood Pressure Respiratory Problems
Allergy - Codeine Artificial Joints Epilepsy/Seizure HIV Rheumatic Fever
Allergy - Erythromycin Asthma-Mild/Mod Excessive Bleeding Jaundice Rheumatism
Allergy - Hay Fever Asthma-Severe Fainting Kidney Disease Sinus Problems
Allergy - Latex Autism Glaucoma Liver Disease Stomach Problems
Allergy - Other Blood Disease Head Injuries Mental Disorders Stroke
Allergy - Penicillin Cancer Heart Disease Nervous Disorders Tuberculosis
Allergy - Sulfa Developmental Dis. Heart Murmur Other Tumors
Anemia Diabetes Hepatitis Radiation Treatment Ulcers

Please explained any marked items above:

Does your child have any other conditions, diseases, or allergies, etc? Yes No If YES, please explain in space below:

Teenage female patient only: Is your teen pregnant? If YES, when is the due date? [mm/yyyy]

DENTAL HISTORY:

What is the reason for your child's dental visit today?

When was your child's last visit to the dentist (if to a different office)? [MM/DD/YYYY]

What was done on your child's last dental visit (if to a different office)

Prior Dentist's name, address, & phone#:

How frequently do you (or does your child) brush his/her teeth? 3(+) a day Twice a day Once a day Seldom
How frequently do you (or does your child) floss his/her teeth? 1(+) a day A few times a week Seldom

Please indicate YES or No in response to the following questions:

- Yes No Do your child's gums bleed during brushing or flossing?
Yes No Do your child's teeth experience sensitivity to cold or hot temperatures?
Yes No Are any of your child's teeth currently causing him/her pain?
Yes No Does your child grind his/her teeth?

If any of the previous questions are marked, please explain:

If you could change anything about your child's mouth, teeth, or smile, what would it be?

CONFIRMATION OF ACCURACY:

Please check here and sign below to confirm that: "To the best of my knowledge, all of the preceding information is true and correct. If there is ever a change in my child's health, I will inform the office at my child's next dental appointment without fail."

[Print name of parent or legal guardian] X [Signature] [Date (mm/dd/yyyy)] [Doctor (office use)]