Medical History Form

In order to ensure that your child receives the best care at our practice, we ask you to carefully complete this form. It is important for us to know about all parts of your child's health history. This form is completely confidential, and will be used only for dental and medical reasons.

Patient Information:

Child's Name: _____ DOB: _____ Age: ____ Sex: ____

Nickname: _____ S.S.#: _____

Physician Information:

Child's Physician/Pediatrician: _____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Date of last physical exam: _____

Medical History

How is your child's general health? _____

Has your child had any serious illness? ___Yes ___No

If yes, please explain _____

Has your child ever been hospitalized? ___Yes ___No

If yes, where, when, and why? _____

Has your child undergone surgery in the past? ___Yes ___No

If yes, where, when and for what reason? _____

Was General Anesthesia used? ___Yes ___No

Were there any complications? ___Yes ___No

If yes, please explain _____

Have you ever been told that your child needs to take antibiotics before dental treatment?

___Yes ___No

MEDICAL HISTORY

Medical conditions: Does your child have any history of the following? *(Please check all that apply)*

	Yes	No		Yes	No
Abuse (physical or sexual)	☐	☐	Hepatitis/Liver Disease	☐	☐
Anemia	☐	☐	HIV Infection (AIDS)	☐	☐
Arthritis	☐	☐	Learning Disability	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
ADD/ADHD	☐	☐	Leukemia	☐	☐
Autism/Asperger's/PDD	☐	☐	Type_____		
Bleeding (prolonged)	☐	☐	Meningitis	☐	☐
Blood Transfusion	☐	☐	Nutritional Deficiency	☐	☐
Brain/Physical Injury	☐	☐	Orthopedic Problems	☐	☐
Cancer:	☐	☐	Rheumatic Fever	☐	☐
Type_____			Scarlet Fever	☐	☐
Cerebral Palsy	☐	☐	Seizures	☐	☐
Cleft Lip/Palate	☐	☐	Type_____		
Developmental Delay	☐	☐	Sickle Cell Disease/Trait	☐	☐
Diabetes	☐	☐	Sleep Apnea (snoring)	☐	☐
Emotional Disability	☐	☐	Speech Problems	☐	☐
Endocrine Disturbance	☐	☐	Spina Bifida	☐	☐
Fainting/Frequent Headaches	☐	☐	Syndrome:	☐	☐
Gastrointestinal Disorder	☐	☐	Type_____		
Hearing/Vision Loss	☐	☐	Tuberculosis	☐	☐
Heart Disease/Murmur:	☐	☐	Any other medical problems not listed above:		
Type_____			_____		
Antibiotics Required?	☐	☐	_____		

If you checked yes for any of the above, please explain below

_____
_____
_____

Medications: Is your child **CURRENTLY** taking any medications?

Drug	Dosage and Frequency	Reason

Allergies: Has your child had an allergic reaction to any of the following: ___Yes ___No

Antibiotics _____
Other Medications _____
Latex_____
Dental Anesthetics _____
Food _____
Other _____

Immunizations: Are your child's immunizations current? ___Yes ___No

DENTAL HISTORY

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

If your child has been to a dentist previously:

When was the last visit? _____Were x-rays taken? ___Yes ___ No When: _____
Name of dentist? _____

How did your child react? _____

Has your child had local anesthetic? ___Yes ___No

If yes, were there any problems? _____

Fluoride: Has your child had fluoride in any of the following forms?

Fluoride tablets or fluoride multivitamins? ___Yes ___No

Drinking water (community/tap water fluoridation)? ___Yes ___No

Professional topical application? ___Yes ___No

Fluoride rinses? ___Yes ___No

Toothpaste? ___Yes ___No

Brushing:

Does your child brush his/her own teeth? ___Yes ___No

Do you help brush your child's teeth? ___Yes ___No

How many times a day does he/she brush? ____ Times ___A.M. ___P.M.

Do you help your child floss their teeth? ___Yes ___No

Diet:

Is/was your child breast-fed? ___Yes ___No

If yes, until what age? _____

Does/Did your child sleep with the bottle ___Yes ___No

If yes, what is/was in the bottle? ___Milk ___Juice ___Water ___Other_____

If they no longer do, at what age did they stop? _____

Does your child snack frequently? ___Yes ___No

If yes, what do those snacks usually consist of? _____

How much soda and juice does your child usually drink per day? _____

Trauma: Have your child's teeth ever been injured? ___Yes ___No

When (age)? _____

Which teeth? _____

Cause? _____

Did he/she receive treatment? ___Yes ___No

If yes, describe treatment _____

Habits: Does your child have any of the following habits? (Indicate inclusive ages)

Thumb or finger sucking? ___Yes ___No

Pacifier sucking? ___Yes ___No

Mouth breathing? ___Yes ___No

Grinding of teeth? ___Yes ___No

Has your child received any unusual dental or surgical treatment to the mouth?

___Yes ___No

If yes, describe: _____

Is there anything else you would like to tell us regarding your child's dental health?

_____
_____
_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Name: _____ Signature: _____

Relationship patient: _____ Date: _____

***Reviewed by*:**

Doctor_____ Date: _____