Medical History

Child's Physician: _____

Phone #: (_____)_____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

_____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Are Immunizations Current? ☐ Yes ☐ No

Please list all medications that the child is currently taking: _____

Please list all medications / foods / other that cause the child allergic reactions: _____

Has the child been diagnosed with or treated for any of the following:

Y N Abnormal Bleeding	Y N Cleft Palate / Lip	Y N Hepatitis Type ____
Y N AIDS/HIV+	Y N Diabetes	Y N High / Low Blood Pressure
Y N Anemia	Y N Epilepsy / Seizures	Y N Hives
Y N Any Hospital Stays/Surgeries	Y N Handicaps / Disabilities	Y N Kidney Problems
Y N Asthma	Y N Hearing / Speech	Y N Liver Problems
Y N Blood Transfusion	Y N Heart Disease	Y N Rheumatic Fever
Y N Cancer	Y N Heart Murmur	Y N Sickle Cell Anemia
Y N Cerebral Palsy	Y N Hemophilia Type ____	Y N Tuberculosis (TB)

Please discuss the above and any other medical problems the child has / had: _____

_____

_____

Do you consider your child to be: ☐ Progressing normally in the learning process ☐ Slow in the learning process

Dental History

What is the ***primary*** reason for today's visit? _____

Is your child currently having problems with any of the following?

☐ Cavities	☐ Toothache	☐ Sensitive Teeth	☐ Trauma
☐ Gum Infection	☐ Color of Teeth	☐ Tooth Alignment	☐ Other _____

Has the child experienced problems with previous dental work? ☐ Yes ☐ No Explain: _____

Is the child's home water supply fluoridated? ☐ Yes ☐ No

Does the child brush his / her teeth daily with fluoride toothpaste? ☐ Yes ☐ No

Do you give the child any other form of fluoride? ☐ Yes ☐ No If yes, what? _____

Does the child floss his / her teeth daily? ☐ Yes ☐ No

Was your child bottle / breast-fed? ☐ Yes ☐ No If yes, what age was it completely stopped? _____

Does your child suck a finger / thumb / pacifier / or exhibit any other habits? _____

Previous/Present (circle) Dentist: _____ Date of last Visit: _____

Why did you leave your last dentist? _____

What did you like most about any dentist you have seen?_____ Least?_____

_____

Signature _____ Date _____

Relationship to Child _____