Child Medical-Dental History

Childs Medical History

Name of child's physician:____

Physician Phone:____

Does your child have any allergies to medications? Yes / No

If yes, please list:

____
____
____

Any reaction to local anesthetic? Yes / No

Circle all that apply to your child:

Asthma-- Yes / No

Heart Disease/Murmur------------------------------------Yes / No

Diabetes--- Yes / No

Arthritis--Yes / No

Prolonged Bleeding-- Yes / No

Hepatitis-- Yes / No

Lung Disease-- Yes / No

Birth Defects-- Yes / No

Hearing Loss--- Yes / No

Epilepsy or Seizures--------------------------------------- Yes / No

Emotional Problems-- Yes / No

Physical or Mental Disability---------------------------- Yes / No

Kidney Disease-- Yes / No

Hay Fever--- Yes / No

Anemia-- Yes / No

AIDS / AIDS Related Complex-------------------------- Yes / No

Please list any other medical concerns or conditions that were not listed above:____
____
____

Child's Dental History

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

Routine Care ____ Emergency ____

Is this your child's first dental visit?

Yes _____ No_____

If not, was the previous visit a good one?

Yes _____ No _____

Has your child received local anesthetic before?

Yes _____ No ______

Does your child have a bottle or beverage other than water before nap or bed time?

Yes ______ No ______

Does your child have a thumb habit or pacifier?

Yes _____ No ______

Who brushes your child's teeth?____

How often are your child's teeth brushed?____

How often are your child's teeth flossed?____

Has your child had a serious problem at a previous dental visit?

Yes ____ No ____

If yes, Please explain:

____
____

Do you believe your child can tolerate routine dental care?

Yes ______ No ______

If not, please explain:

____
____
____

I have completed this medical-dental history form about my child, and by signing below I attest to the accuracy of the information provided,

Guardian Signature:____________________________Date___________