Children's Dental Care Medical History(Copy)(Copy)

Patient Name: Birth Date: Date Created:

DENTAL HISTORY

Is this the patient's first visit to a dentist? ○ Yes ○ No

When was the patient's last dental visit? Were the teeth cleaned at that time? ○ Yes ○ No If yes

Does the patient eat between meals? ○ Yes ○ No

Does the patient eat well balanced meals? ○ Yes ○ No

Does the patient eat or drink the following foods?

candy	○ Yes ○ No	soda pop	○ Yes ○ No	fruit juice	○ Yes ○ No	chewing gum	○ Yes ○ No
flavored milk	○ Yes ○ No	chewy fruit flavored snacks	○ Yes ○ No				

Have any cavities been noted in the past? ○ Yes ○ No

Has the patient ever been treated with fluoride? ○ Yes ○ No

Is there fluoride in the patient's drinking water? ○ Yes ○ No

Is there a family history of cavities? ○ Yes ○ No

Has there been any injuries to the patient's mouth involving the teeth? ○ Yes ○ No If yes

Has the patient ever had sealants placed on any teeth? (If "yes", at what dental office and date of ○ Yes ○ No If yes

When does the patient brush their teeth?

Before school	○ Yes ○ No
After eating meals or snacks	○ Yes ○ No
Before going to bed	○ Yes ○ No

MEDICAL HISTORY

Is the patient in good health? ○ Yes ○ No

Does the patient see primary care physician? (If "yes" please give us the physician's name) ○ Yes ○ No If yes

Is the patient is taking any medications? (If "yes" please list all of them) ○ Yes ○ No If yes

Has the patient had any serious illness? (if "yes", please indicate what type of illness and when the ○ Yes ○ No If yes

Does patient have any allergies? (If "yes", list all) ○ Yes ○ No If yes

Has the patient ever had surgery? (if "yes", please indicate what type of surgery/name of doctor and ○ Yes ○ No If yes

Is there a surgery contemplated in the future? (If "yes" please describe-type of surgery/name of ○ Yes ○ No If yes

Does the patient smoke, chew, use snuff or any other forms of tobacco? (Describe) ○ Yes ○ No If yes

Does the patient have a heart condition? (If "yes", Name of cardiologist/year of diagnosis and is ○ Yes ○ No If yes

Does the patient take birth control medication? Is the patient pregnant or is there suspicion of ○ Yes ○ No If yes

Has the patient tested positive or been diagnosed with any of the following?

Diabetes	○ Yes ○ No	Heart Disease/Trouble	○ Yes ○ No	Asthma	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Tooth Ache	○ Yes ○ No
Ear Infection	○ Yes ○ No	Down's Syndrome	○ Yes ○ No	Autism	○ Yes ○ No
ADD (Attention Deficit Disorder)	○ Yes ○ No	ADHD (Attention Deficit Hyper Disorder)	○ Yes ○ No	Rheumatoid Arthritis	○ Yes ○ No
Artificial Joints/Prothesis	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Epilesy or Seizure Disorder	○ Yes ○ No	Liver Disease	○ Yes ○ No	Orthopedic Surgery/Ortho Hardware	○ Yes ○ No
AIDS/HIV positive	○ Yes ○ No	Hepatitis A, B or C	○ Yes ○ No	T.B. (Tuberculosis)	○ Yes ○ No
Dizziness/Fainting	○ Yes ○ No	Convulsions	○ Yes ○ No	Blood Disorder	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Cancer	○ Yes ○ No	Chemotherapy	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No
Frequent Headaches	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Hay Fever	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No		

Is there anything else we should know about the patient's health not covered in this form? ○ Yes ○ No If yes

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signature of Parent or Guardian:

X Date:_____