DENTAL HISTORY

Why is your child here today? _____

Is your child currently taking fluoride? _____ How often? _____

Has your child been to the Dentist before? _____ Date _____

How was your child's experience? _____

Has your child had x-rays before? _____ Date_____

Is your child currently on the bottle? _____ Pacifier? _____ Sippy cup? _____

Nursing? _____ Thumb sucking? _____ Grinding? _____

Do you currently help your child brush and floss?_____

How often does your child brush? _____

MEDICAL HISTORY

Name of Physician _____

Date of last physical exam _____ Any findings _____

Is your child's immunization up to date?_____ Date _____

Date of your child's last tetanus _____ Booster _____ Any immunizations due? _____

Is your child currently taking medication? _____ If yes, what?_____

Is your child currently under the care of a physician for any reason? _____

If yes, for what?_____ Date _____

Has your child ever had a traumatic medical or dental injury? _____

If yes, for what?_____ Date _____

Has your child ever been hospitalized? _____

If yes, for what?_____ Date _____

DOES YOUR CHILD HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING?
PLEASE CIRCLE ALL THAT APPLY TO YOUR CHILD

Autism	Y	Breathing / Lung Problems	Y	Mental / Physical	
ADHD	Y	Cancer / Tumor	Y	Developmental Delay	Y
AIDS	Y	Congenital Birth Defects	Y	Pregnancy-Due _____	Y
Allergy to Latex	Y	Multiple Ear Infections	Y	GI System	Y
Allergies / Adverse Reaction		Tubes in ears	Y	Radiation Treatment	Y
to Medication	Y	Endocrine System	Y	Respiratory Treatment	Y
If yes, what type of Medication?		Fainting	Y	Respiratory Problem	Y
_____		Hearing / Sight	Y	Seizures	Y
Other Allergies	Y	Heart Murmur	Y	Tuberculosis	Y
_____		Heart Condition	Y	Down Syndrome	Y
Asthma	Y	Head Injury	Y	Vomiting / Diarrhea	Y
Blood Disease / Disorder	Y	Headaches		Frequent Infection	Y
Blood Transfusion	Y	Frequent / Recurrent	Y	If yes, what type? _____	
If yes, date_____		Kidney Disease	Y	Any other medical conditions not listed	
Behavioral / Learning		Liver Disease	Y	_____	
Disorder	Y	Mental Disorder	Y	_____	

I have read the above and have answered them to the best of my knowledge. I have updated this form as requested.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____