

Dental & Medical History

Why did you bring the child to the dentist today? _____

Has the child ever taken any diet pills such as Phen-Fen? Yes No
 (Also known as Redux or Pondimin.) If so, when? _____

Is the child currently in pain? Yes No

Does the child require antibiotics before dental treatment? Yes No

Has the child ever had a serious/difficult problem associated with previous dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

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

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

Please list all drugs that the child is currently taking:

Please list all drugs/things that the child is allergic to:

Has the child experienced the following medical problems?

- | | |
|------------------------------------|---------------------------|
| Y N Abnormal Bleeding | Y N Heart Murmur |
| Y N ADD/ADHD | Y N Hemophilia |
| Y N AIDS/HIV+ | Y N Hepatitis |
| Y N Anemia | Y N High Blood Pressure |
| Y N Any Hospital Stays/Operations? | Y N Hives |
| Y N Artificial Bones/Joints/Valves | Y N Kidney Problems |
| Y N Asthma | Y N Liver Problems |
| Y N Cancer | Y N Low Blood Pressure |
| Y N Chicken Pox | Y N Measles |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Convulsions | Y N Mononucleosis |
| Y N Diabetes | Y N Prosthetics |
| Y N Epilepsy | Y N Rheumatic Fever |
| Y N Exposed to HIV, but Neg. | Y N Scarlet Fever |
| Y N Handicaps/Disabilities | Y N Skin Rash |
| Y N Hearing Impairment | Y N Tuberculosis (TB) |

Are the child's immunizations current? Yes No

Anything you would like to discuss with the Doctor in private? Yes No

Please discuss any serious medical problems the child experiences/ed:

Does/did the child have any of the following habits?

- | | |
|------------------------------|---------------------------|
| Y N Breast Fed | Y N Nursing Bottle Habits |
| Y N Chewing on Objects | Y N Speech Problems |
| Y N Clenching/Grinding Teeth | Y N Thumb/Finger Sucking |
| Y N Lip Sucking/Biting | Y N Tongue/Cheek Biting |
| Y N Mouth Breather | Y N Tongue Thrust |
| Y N Nail Biting | Y N Used Pacifier |

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____

Date _____

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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Signature of Dentist _____

Date _____

Dentist's Comments: _____

Medical History Update

Has there been any change in your child's health status since their last visit? Y N
 If Yes, please explain. _____

Parent/Guardian Signature _____

Date _____

Dentist Signature _____

Date _____

Has there been any change in your child's health status since their last visit? Y N
 If Yes, please explain. _____

Parent/Guardian Signature _____

Date _____

Dentist Signature _____

Date _____