PEDIATRIC MEDICAL AND DENTAL HEALTH HISTORY

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CHILD'S NAME ______________________ DATE OF BIRTH ______________
FATHER'S NAME ______________________ MOTHER'S NAME ______________
NO. OF SIBLINGS ____________ CHILD'S FAVORITE HOBBY ______________
ANY PETS ____________ CHILD'S FAVORITE SPORT ______________
PHYSICIAN'S NAME ______________________ ADDRESS ______________
REASON FOR VISIT ______________________________________
HOW DID YOU HEAR ABOUT OUR OFFICE? ______________ E-mail: ______________

MEDICAL HISTORY

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?	YES	NO
1. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE		
2. CONGENTITAL HEART DISEASE OR HEART MURMUR		
3. ALLERGIES: A) FOOD, DUST, ETC. B) DRUG, (i.e.: Penicillin) C) UNKOWN		
4. ASTHMA OR HAY FEVER		
5. ARTHRITIS OR RHEUMATISM (PAINFUL SWOLLEN JOINTS)		
6. DIABETES/BLOOD SUGAR PROBLEM		
7. ANY PROLONGED BLEEDING OR BRUISES EASILY		
8. KIDNEY OR BLADDER PROBLEMS		
9. ANEMIA OR BLOOD DISORDERS		
10. TUBERCULOSIS OR PNEUMONIA		
11. LIVER PROBLEM, JAUNDICE OR HEPATITIS		
12. GLANDULAR OR HORMONAL PROBLEMS		
13. ACCIDENTS OR SEVERE INFECTIONS		
14. CONVULSION, SEIZURES, FAINTING OR EPILEPSY		
15. HIGH/LOW BLOOD PRESSURE		
16. SPEECH, LEARNING OR HEARING DISORDERS		
17. CHILDHOOD ILLNESSES		
18. IMMUNIZATIONS ARE CURRENT		
19. OTHER, IF SO EXPLAIN		
IF ANY YES ANSWERS, PLEASE EXPLAIN		

DENTAL HISTORY

	YES	NO
1. DATE OF LAST DENTAL VISIT		
2. WHAT TREATMENT WAS RECEIVED?		
3. ANY PREVIOUS UNHAPPY MEDICAL OR DENTAL VISITS?		
4. HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS?		
5. ANY INJURIES TO MOUTH, TEETH, HEAD?		
6. ANY MOUTH HABITS: THUMBSUCKING, NAIL BITING, MOUTH BREATHING, ETC.?		
7. ANY LOST TEETH?		
8. DOES YOUR CHILD BRUSH DAILY?		
9. DO YOU ASSIST CHILD WITH BRUSHING?		
10. HOW OFTEN?		
11. IS DENTAL FLOSS USED?		
12. ARE DISCOLORING TABLETS USED?		
13. HOW DOES YOUR CHILD RECEIVE FLUORIDE? ____WATER ____TOOTHPASTE ____TABLET		
____DENTIST ____VITAMIN ____NONE ____OTHER		
14. CHILD'S ATTITUDE TOWARD DENTISTRY:		
15. ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS?		

I hereby certify the foregoing information is true and correct, because ______________________ is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be completed Authorization is hereby granted as such. Furthermore, I will be responisible for any professional fees incurred for dental services to my child.

Signed ______________________ **Date** ______________