

MEDICAL HISTORY

Patient Name _____	Medical Alert _____
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1. Have your child been under the care of a medical doctor during the past two years?.....

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Is your child taking any medication, drugs or pills now?.....

If yes, please list name and dosage _____

3. Is your child aware of having an allergic (or adverse reaction) to any medication,.....

If yes, please list: _____

4. Has your child been a patient in the hospital during the past five years?.....

5. Indicate which of the following your child have had, or have at present Circle "yes" or "no" to each item.

Heart Murmur.....	Yes No	Hay fever.....	Yes No	Blood Transfusion.....	Yes No
Rheumatic Fever.....	Yes No	Latex Sensitivity.....	Yes No	Hemophilia.....	Yes No
Kidney Trouble.....	Yes No	Allergies or Hives.....	Yes No	Sickle Cell Disease.....	Yes No
Ulcers.....	Yes No	Sinus Trouble.....	Yes No	Bruise Easily.....	Yes No
Diabetes.....	Yes No	Radiation Therapy.....	Yes No	Liver Disease.....	Yes No
Thyroid Problems.....	Yes No	Chemotherapy.....	Yes No	Yellow Jaundice.....	Yes No
Contact lenses.....	Yes No	Tumors.....	Yes No	Neurological Disorders.....	Yes No
Emphysema.....	Yes No	Hepatitis A (infectious)(serum).....	Yes No	Epilepsy or Seizures.....	Yes No
Chronic Cough.....	Yes No	A.I.D.S.....	Yes No	Fainting or Dizzy Spells.....	Yes No
Tuberculosis.....	Yes No	H.I.V. Positive.....	Yes No	Nervous/Anxious.....	Yes No
Asthma.....	Yes No	Cold Sores/Fever Blisters.....	Yes No	Psychiatric/Psychological Care.....	Yes No

6. Does Your child have _____ any disease, condition, or problem not listed?.....

If yes, please list:

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my child's health or medication.

Parent/Guardian Signature _____ Date _____

Dental & Medical History Review



Doctor Signature _____ Date _____

DENTAL HISTORY

Patient Name _____	Medical Alert _____
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*Welcome! so that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.*

What is the reason for you child visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your child last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you does child have dental examinations? _____

How often does your child brush teeth? _____ How often does your child floss? _____

Are any of your child teeth sensitive to:

Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Has your child noticed any mouth odors or bad tastes? Yes No
Does your child frequently get cold sores, blisters or any other oral lesions? Yes No

Has your child:

Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal treatment? Yes No
Your child teeth ground or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

Does your child:

Clench or grind your child teeth while awake or asleep? Yes No
Bite your child lips or cheeks regularly? Yes No
Hold foreign objects with your child teeth? Yes No
(pencils, pipe, pins, nails, fingernails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No

Has your child experienced:

Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty in opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Does your child nervous about having dental treatment? Yes No

If so, what is your child biggest concern? _____

Has your child ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you and your child would like us to know? Yes No

If yes, please describe _____

(Please complete other side)

