MEDICAL HISTORY

1) Does your child have any health problems? ☐ Yes ☐ No
   If yes, explain____________________
2) Is your child currently seeing a physician for any problems? ☐ Yes ☐ No
   If yes, explain____________________
3) Did your child have any health problems or illnesses when younger ☐ Yes ☐ No
   If yes, explain____________________
4) Does your child take any medications? ☐ Yes ☐ No
   If yes, please list including dose____________________

   ____
5) Has your child ever had allergic or bad reactions to foods or medicines? ☐ Yes ☐ No
   If yes, explain____________________
6) Has your child ever been injured or stayed in a hospital overnight? ☐ Yes ☐ No
   If yes, explain____________________
7) Is your child pregnant or has been pregnant in the past? ☐ Yes ☐ No
   Is the child taking a contraceptive pill? ☐ Yes ☐ No
8) Has your child ever had a blood transfusion? ☐ Yes ☐ No
9) Has your child ever had any of the following? ☐ Yes ☐ No
   - Blood problems such as sickle cell anemia ☐ Yes ☐ No
   - Easy bleeding or bruising ☐ Yes ☐ No
   - Seizures or fainting spells ☐ Yes ☐ No
   - Frequent headaches ☐ Yes ☐ No
   - Heart murmur, heart defect or rheumatic heart fever ☐ Yes ☐ No
   - Breathing problems or asthma ☐ Yes ☐ No
   - Tuberculosis (T.B.) ☐ Yes ☐ No
   - Hepatitis or liver problems ☐ Yes ☐ No
   - Stomach or bowel problems ☐ Yes ☐ No
   - Diabetes (sugar), endocrine or hormone problems ☐ Yes ☐ No
   - Kidney problems ☐ Yes ☐ No
   - Hives or skin rash ☐ Yes ☐ No
   - AIDS or HIV infection ☐ Yes ☐ No
   - Venereal disease ☐ Yes ☐ No
   - Birth defect or disability ☐ Yes ☐ No
10) Does your child have any behavior or learning problems? ☐ Yes ☐ No
    What grade at school is he/she in?____________________
11) Has your child had any disease or condition not listed above? ☐ Yes ☐ No
    If yes, explain____________________
12) Name of your child's pediatrician or family physician____________________
    Address ____________________ Phone ____________
    Date of last physical examination ____________

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

____________________ ____________

SIGNATURE OF PARENT/ LEGAL GUARDIAN DATE

DENTAL HISTORY

1. Why did you bring your child to the dentist today?____
____
____

2. Is this his/her first visit to the dentist? ☐ Yes ☐ No

   If no, date of last examination____

   Type of treatment received ☐ Cleanings ☐ Fillings ☐ Emergency care

   Have you been satisfied with your child's past dental treatment? ☐ Yes ☐ No

   If no, why not?____

3. Has your child cried or been upset during previous dental or medical care? ☐ Yes ☐ No

   If yes, explain____

   Do you think he or she will cry or be upset for dental treatment today? ☐ Yes ☐ No

   If yes, explain____

4. Has your child ever had any of the following problems? (Please check all that apply)

   ☐ Finger or thumb habits
   ☐ Pacifier habit
   ☐ Clenching or grinding teeth
   ☐ Mouth breathing
   ☐ Speech problems
   ☐ Toothaches
   ☐ Abscesses (gum boils)
   ☐ Bleeding gums
   ☐ Injury to face, mouth or front teeth
   ☐ TMJ problems

5. Does or did your child ever go to bed with the bottle? ☐ Yes ☐ No

   How old was he/she when he/she no longer used a bottle?____________________________

6. Does your child use a sippy cup? ☐ Yes ☐ No

7. How often are your child's teeth brushed?____

8. How often does he/she floss?____

9. Does the toothpaste you use for your child contain fluoride ☐ Yes ☐ No

10. What's your child's favorite beverage?____

11. What type of water do you drink at home?

    ☐ Tap water ☐ Tap water reverse osmosis filtered ☐ Bottled water ☐ Other

12. What does your child typically eat for snacks?__________________________