MEDICAL AND DENTAL HISTORY FORM

Patient Name: _____ (Last), _____ (First) _____ (MI) _____ (Preferred Name) Chart# _____ (office use only)

Please take a moment to let us know about your child's medical and dental history so we may serve your child more effectively and in a way that watches out for his/her overall health and well-being.

MEDICAL HISTORY:

Your child's Pediatrician or Primary Care Physician's name, address, & phone number (if available):

Please indicate YES or No in response to the following questions:

- ☐Yes ☐No Would you consider your child to be in fairly **good health?**
- ☐Yes ☐No Within the past year, has there been **any changes** in your child's general health?
- ☐Yes ☐No Does your child require **antibiotic PRE-medication** before dental treatments (SBE prophylaxis)?
- ☐Yes ☐No Has your child or family members ever had **complications** following a dental treatment, sedation, or general anesthesia?
- ☐Yes ☐No Is your child **currently under the care of a physician** due to a specific condition?
- ☐Yes ☐No Has your child ever **been hospitalized** due to a surgery or illness?
- ☐Yes ☐No Does your child have **snoring, obstructive sleep apnea,** or **mouth breathing**?

If any of the previous questions are marked YES, please explain:

☐Yes ☐No Is your child currently taking any prescription or non-prescription **medications?**

If YES, please list below, medication **names, dosage, frequency** taken, and **what conditions they are taken for**.

Please indicate if your child **has experienced** any of the following currently or in the past:

☐**ADHD**	☐Artificial Joints	☐Dizziness	☐Hepatitis	☐Radiation Treatment
☐Allergy – Erythromycin	☐**Asthma-Mild/Mod**	☐Epilepsy/Seizure	☐High Blood Pressure	☐Respiratory Problems
☐Allergy – Hay Fever	☐**Asthma-Severe**	☐Excessive Bleeding	☐HIV	☐Rheumatism
☐**Allergy – Latex**	☐**Autism**	☐Fainting	☐Kidney Disease	☐Sinus Problems
☐Allergy – Other	☐Blood Disease	☐Glaucoma	☐Liver Disease	☐Stomach Problems
☐**Allergy – Penicillin/Amox**	☐Cancer	☐**Head Injuries**	☐Mental Disorders	☐Tuberculosis
☐Allergy – Sulfa	☐**Developmental Dis.**	☐**Heart Disease**	☐Nervous Disorders	☐Tumors
☐Anemia	☐Diabetes	☐**Heart Murmur**	☐Other	☐Ulcers

Please explained any marked items above:

☐Yes ☐No? Does your child have **any other conditions, diseases, or allergies,** etc? If YES, please explain in space below:

Female patient only: Is your teen **pregnant**? If YES, when is the due date? ____/____ (mm/yyyy)

DENTAL HISTORY:

What is the reason for your child's dental visit today? Any specific questions or concerns?

When was your child's last visit to a dentist (if to a different office)? ____/____/____ (MM/DD/YYYY)

What was done for your child's last dental visit (if to a different office)?

How frequently do you (or does your child) **brush** his/her teeth? ☐3(+) a day ☐Twice a day ☐Once a day ☐Seldom

How frequently do you (or does your child) **floss** his/her teeth? ☐1(+) a day ☐A few times a week ☐Seldom

Please indicate YES or No in response to the following questions:

- ☐Yes ☐No Does your child's **gum bleed** during brushing or flossing?
- ☐Yes ☐No Does your child's experience **tooth sensitivity to cold or hot** temperatures?
- ☐Yes ☐No Are any of your child's teeth currently causing him/her **pain**?
- ☐Yes ☐No Does your child **grind** his/her teeth?

If any of the previous questions are marked, please explain:

CONFIRMATION OF ACCURACY:

Please sign below to confirm that: "To the best of my knowledge, all of the preceding information is **true and correct**. If there is ever a change in my child's health, I will inform the office before or at my child's next dental appointment without fail."

_____ (Print name of parent or legal guardian) X_____ (Signature) ____/____/____ (Date mm/dd/yyyy) [_____] (Doctor office use)