**Child Medical History**

Current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes  No Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your child** **allergic to any of the following?**

Amoxicillin Erythromycin Penicillin

Aspirin Jewelry Sulfa Drugs

Codeine Latex Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Anesthetics

**Please list all current medications:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has the child experienced any of the following?**

Y N Acid Reflux Y N Eyesight Issues Y N Seizures

Y N Asthma Y N Headaches Y N Snoring

Y N Congenital Heart Defect Y N Heart Murmur Y N HIV/AIDS

Y N Depression/Anxiety Y N Hearing Impaired Y N Hepatitis: Type \_\_\_\_\_\_\_\_\_

Y N Diabetes Y N Learning/Behavior Issues Y N Premed Required

Y N Dizziness

Other Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

Last Dental Visit \_\_\_\_\_\_\_\_\_\_ Last X-rays taken\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had any of the following:

Y N Injuries to mouth/teeth: Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Sealants Placed

Y N Baby teeth removed: Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N History of Cavities

Y N Issues with past dental treatment: Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Nitrous Oxide

Does your child Eat Candy Y N Chew Gum Y N Drink Soda Y N

When does your child brush his/her teeth?

Morning After Meals Before Bedtime

Does your child floss? Yes No If yes, how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child receive fluoride?

Community Water Fluoride Drops/Tablets Fluoride Rinse/Gel Well water

Other Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 the office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Patient/Guardian/Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_