Child Medical and Dental History

Date ______________________

Child's Name ______________________________________ Preferred Name ______________________________
Parent or Guardian ____________________________Child's Birthday _____/_____/_____Gender M F
Reason for Visit ____
Child's Pediatrician____ Phone # ______________________________
Has child been seen by a physician in the last year? Yes No __________________________________
Has child ever been hospitalized? Yes No ____
Has child ever had surgery? Yes No ____
List Current Medications ____
Is child allergic to any medications? Yes No Indicate Allergies: ___________________________________
Any other allergies? Yes No ____________________________________

Has child ever had any of the following? (Please circle either YES or NO)

		Comments			Comments
AIDS (HIV)	Yes / No	______________	Autism	Yes / No	______________
Anemia/Blood Problems	Yes / No	______________	Bed Wetting	Yes / No	______________
Arthritis	Yes / No	______________	Cerebral Palsy	Yes / No	______________
Asthma	Yes / No	______________	Chicken Pox	Yes / No	______________
Bleeding Problems	Yes / No	______________	Cleft Lip / Palate	Yes / No	______________
Cold Sores/Herpes	Yes / No	______________	Down's Syndrome	Yes / No	______________
Diabetes	Yes / No	______________	Emotional Problems	Yes / No	______________
Heart Murmur	Yes / No	______________	Eye Problems	Yes / No	______________
Hepatitis A, B or C	Yes / No	______________	Object / Fingernail Biting	Yes / No	______________
High Blood Pressure	Yes / No	______________	Hearing Problems	Yes / No	______________
Kidney Problems	Yes / No	______________			
Liver Problems	Yes / No	______________	Heart Problems	Yes / No	______________
Mitral Valve Prolapse	Yes / No	______________	Hyperactivity	Yes / No	______________
Rheumatic Fever	Yes / No	______________	Learning Disability	Yes / No	______________
Seizures/Epilepsy	Yes / No	______________	Measles / Mumps	Yes / No	______________
Sickle Cell Problems	Yes / No	______________	Mental Retardation	Yes / No	______________
Thyroid Problems	Yes / No	______________	Mouth Breathing	Yes / No	______________
Tuberculosis (TB)	Yes / No	______________	Physical Handicap	Yes / No	______________
Tumor/Cancer	Yes / No	______________	Speech Problems	Yes / No	______________
Psychiatric	Yes / No	______________	Thumb Sucking	Yes / No	______________
Yellow Jaundice	Yes / No	______________	Tongue Thrust	Yes / No	______________
ADD / ADHD	Yes / No	______________			

Is there anything not listed above that we should know about your child? ______________________________
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Has there ever been any injury to any of the teeth or mouth? _____________ If yes, please explain______
How often does child brush his/her teeth? ____
Do you help your child brush? ____
At what age did child get first tooth? _____________ Walk? ________________ Talk? ________________
Did child ever take a bottle to bed at night? ________At what age did child stop using the bottle? _____________
Has any member of your family had any unusual dental problems? _______________________________

To the best of my knowledge the above questions have been accurately answered .

______________________________ ______________________ _____________
Parent/Guardian Signature Relationship to Patient Date