Patient's Name_____ **Date**_____

I. Medical History

Child's Physician_____ Phone_____

Date of last exam _____

☐ Yes ☐ No Is your child allergic to any medicines or foods? If yes, what?_____

_____

☐ Yes ☐ No Is your child taking any medications? If yes, what?_____

_____

☐ Yes ☐ No Has your child ever been hospitalized or had an operation? If yes, explain

_____

☐ Yes ☐ No Does your child have any physical, mental, emotional, or muscular disabilities? If yes, explain_____

_____

☐ Yes ☐ No Does your child have any hearing, sight, speech or learning problems? Please explain_____

☐ Yes ☐ No Does your child need an antibiotic prescription (recommended by your physician, for a heart condition – artificial valves/shunts, etc.) before any dental work?

Please check any that pertain to your child

☐ Heart/Cardiovascular Condition	☐ Allergies	☐ Rheumatic Fever
☐ Liver/Kidney Problem	☐ Asthma	☐ Heart Murmur
☐ Bleeding Disorder	☐ Hepatitis	☐ Sickle Cell Anemia
☐ Epilepsy	☐ Diabetes	☐ HIV/AIDS
☐ ADD/ADHD	☐ Cerebral Palsy	☐ Eczema/Skin Disorders

II. Dental History

☐ Yes ☐ No Is your child experiencing dental pain today? If so, where?_____

☐ Yes ☐ No Is this your child's first visit to the dentist?
If not, how long has it been since the last visit to the dentist?_____
Name of previous dentist _____

☐ Yes ☐ No Were any x-rays taken?

☐ Yes ☐ No Has your child experienced an unfavorable reaction from previous dental care?

☐ Yes ☐ No Does your child have a thumb, finger, or pacifier habit? (circle)

☐ Yes ☐ No Do you have well water?

☐ Yes ☐ No Does your child take fluoride supplements?

☐ Yes ☐ No Does your child take a bottle at night?
How often does your child brush his/her teeth?_____Floss_____
How often do you clean your child's teeth?_____

I have read my child's medical history dated _____ and confirm that it accurately states past and present conditions.

Date	Exceptions/Changes	Parent's Signature	Reviewed by: