

**Dental History**

  Male

Child’s Name: Date of Birth: / /  Female

How did you hear about us? .

Does your child have an unusual history of the following:

 Nursing/Bottle Habits Pacifier Thumb/Finger Sucking Dental Grinding

**MEDICAL HISTORY**

Name of Child’s Physician: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Child taking any medications? Yes No If yes, what? \_\_\_ .

Is Child allergic to any of the following medications or substances? Yes No

 Aspirin Penicillin Latex Foods Metal/Acrylics Other: \_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **AIDS/HIV  YES  NO****Anemia  YES  NO****Asthma/Breathing  YES  NO** **Problems****Autism  YES  NO****Arthritis  YES  NO****ADHD  YES  NO****Birth Defects  YES  NO****Brain Injury  YES  NO****Bruise Easily  YES  NO****Bleeding/  YES  NO** **Clotting Problems****Cancer  YES  NO** | **Cerebral Palsy  YES  NO****Chemotherapy  YES  NO****Child Abuse  YES  NO****Chronic Adenoid/  YES  NO** **Tonsil Problems****Cleft Lip/Palate  YES  NO****Developmentally  YES  NO** **Delayed****Drug/Alcohol Use  YES  NO****Emotional  YES  NO** **Disturbance****Excessive Gagging  YES  NO****Fainting/Dizziness  YES  NO****Fever Blisters  YES  NO** | **Growth Problems  YES  NO****Heart Murmur/  YES  NO** **Heart Problems****Hepatitis/  YES  NO** **Liver Disease** **High Blood Pressure  YES  NO****Bladder Conditions  YES  NO****Kidney Disease  YES  NO****Leukemia  YES  NO****Sickle Cell Anemia  YES  NO****Tuberculosis  YES  NO****Prosthetic Joints/  YES  NO** **Pins** | **Orthopedic  YES  NO** **Problems****Tobacco Use  YES  NO****Pregnancy  YES  NO****Ulcers  YES  NO****Diabetes  YES  NO****Disabilities/  YES  NO** **Special Need****Speech/Hearing  YES  NO** **Problems****Convulsions/  YES  NO** **Seizures** **Tumors/Growth  YES  NO****Psychiatric Care  YES  NO** |

 **PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:**

If answered **‘’YES’’** to any of the above, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Dr’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_