

**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: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_