Patient name: _____ **Date of birth:** _____

Medical History

Child's physician: _____ Phone #: _____
Last seen: _____ Are immunizations current? _____
Problems during pregnancy **Y / N** If yes, explain: _____
Complications during birth **Y / N** If yes, explain: Birth weight: _____
Premature **Y / N** If yes, how many weeks? _____

Has your child had any of the following?

YES / NO			YES / NO			YES / NO	
___	___	Abnormal bleeding	___	___	Cystic Fibrosis	___	___ Hives
___	___	ADD/ADHD	___	___	Diabetes	___	___ Kidney problems
___	___	AIDS/HIV+	___	___	DRUG allergies	___	___ LATEX allergy
___	___	Anemia	___	___	Ear infections or tubes in ears	___	___ Liver problems
___	___	Asthma	___	___	Eating disorder	___	___ RED DYE allergy
___	___	Autism	___	___	Epilepsy	___	___ SEASONAL allergies
___	___	Blood transfusions	___	___	Hearing impairment	___	___ Sickle cell trait
___	___	Cancer	___	___	Heart disorder	___	___ Speech problems
___	___	Cerebral Palsy	___	___	Heart murmur	___	___ Tonsillitis
___	___	Congenital heart defect	___	___	Hemophilia	___	___ Tuberculosis (TB)
___	___	Convulsions/Seizures	___	___	Hepatitis A, B, or C	Other?	_____

Please list all medications that your child is taking: _____
Please list all allergies to medications and reactions: _____
Please list all other allergies (examples: ants, nuts): _____
Has your child ever been hospitalized? **Y / N** _____
Has your child ever had surgery? **Y / N** _____

Dental History

Date of last dental exam/treatment: _____ Where was the last visit? _____
What is the primary reason for today's visit? _____

Does your child?

YES / NO			YES / NO			YES / NO	
___	___	Bottle feed currently	___	___	Clench / grind teeth	___	___ Tongue thrust / Mouth breathing
___	___	Breast feed currently	___	___	Suck thumb / finger / lips	___	___ Drink sodas / juice / sports drinks
___	___	Use Pacifier	___	___	Bite lips / cheek / nails	___	___ Snack frequently

Is your child currently in pain? **Y / N** _____
Has your child had a toothache recently? **Y / N** _____
Has patient had trauma to their mouth or head? **Y / N** _____
Any history of complications following dental treatment? **Y / N** _____
Has mother/father had a lot of tooth decay? **Y / N** _____
Any family history of malocclusions, bad bites, missing teeth, or extra teeth? **Y / N** _____

Oral hygiene

Who brushes patient's teeth? ___ Patient ___ Parent ___ Both
How often are teeth brushed? ___ Less than once a day ___ Once a day (morning) ___ Once a day (night) ___ Twice daily
Type of toothbrush? ___ Manual ___ Electric ___ Uses both
Are patient's teeth flossed? **Y / N** Who flosses? ___ Patient ___ Parent ___ Both
Have you received instructions on proper brushing technique? **Y / N**

Fluoride Adequacy

What is your child's primary source of water? ___ Well water ___ City water ___ Bottled water
Is fluoride toothpaste used at home? **Y / N** If yes, does the patient swallow it? **Y / N**
Does patient use a fluoride rinse? **Y / N** If yes, does the patient swallow it? **Y / N**

To the best of my knowledge, all the preceding answers and information provided are true

Print name:_____ Signature:_____ Date:_____
Reviewed by:_____Date:_____