MEDICAL HEALTH HISTORY

PATIENT NAME: ________________________ Date: ________

Patient Date of Birth:______________________

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Is your child in good health?
2. Yes No Has there been a change in their health within the last year? Explain: ____
3. Yes No Has your child been hospitalized or had a serious illness in the last 2 years? Explain: __________________________________

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4. Yes No Is your child being treated by a physician now? For what? ____

Name of physician: ____ Date of last Medical Exam: ____________________________

B. HAS YOUR CHILD EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Ringing in ears
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever,
9. Yes No Persistent cough,
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Dizziness
14. Yes No Jaundice
15. Yes No Frequent Headaches
16. Yes No Fainting spells
17. Yes No Blurred Vision
18. Yes No Seizures
19. Yes No Excessive thirst
20. Yes No Joint pain, stiffness

C. DOES YOUR CHILD HAVE OR HAS HAD:

21. Yes No Heart disease
22. Yes No Heart defects,
23. Yes No Heart murmur
24. Yes No Eye disease
25. Yes No Skin disease
26. Yes No TB, emphysema or other lung diseases
27. Yes No Hepatitis, A B C
28. Yes No Kidney, bladder diseases
29. Yes No HIV positive or AIDS-ARC
30. Yes No Tumors, Cancer
31. Yes No Rheumatic fever
32. Yes No Anemia
33. Yes No Stomach problems, ulcers
34. Yes No Thyroid, adrenal diseases
35. Yes No Diabetes
36. Yes No Mitral Valve Prolapse

D. DOES YOUR CHILD HAVE OR HAS HAD:

37. Yes No Surgeries _________________________________
38. Yes No Blood Transfusions _________________________
39. Yes No Artificial Joint ______________________________
40. Yes No Contact Lenses _____________________________
41. Yes No Psychiatric Care ____________________________
42. Yes No Radiation Treatments
43. Yes No Chemotherapy
44. Yes No Prosthetic heart valve

45: Other: ____

46. Yes No Currently taking Birth Control Pills
47. Yes No Currently Pregnant

F. VITAMINS & MEDICATIONS: ____

____

____

ALLERGIES: **LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:**

____

G. ALL PATIENTS:

48. Yes No Does your child have or had any other diseases or medical problems NOT listed on this form? If so, please explain:

____

49. Yes No Has your child ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?

DENTAL HEALTH HISTORY

H. Name of your Child's Former Dentist: ___________________________ How long since they were last seen? ______

Yes No Is this your child's first visit to a Dentist?

Yes No Has your child had any problem(s) with dental treatment in the past?

Yes No Has your child ever received a local anesthetic (novocaine)?

Yes No Has your child ever had fillings and/or sealants?

Yes No Has your child ever worn braces? If so, when? ____

Yes No Does your child snack between meals? What snacks do they prefer? ________________________________

Yes No Does your child drink from a bottle or sippy cup?

Yes No Does your child suck their thumb/finger(s) or uses a pacifier? ______________________________________

Yes No How often are you brushing your child's teeth? ____

Yes No How often do you floss their teeth? ____

Yes No Do you have fluoridated water at home?

Yes No Does your child take fluoride supplements daily? If so, what kind and how often?

____

Yes No Does your child drink at least 2 glasses of water a day?

Yes No Have there been any injuries to teeth, such as a fall, blows, chips, etc?

____

Yes No Do you have any special concerns about your child's teeth?

____

Since hereditary is a factor in dental health, how would each parent rate their own teeth? Excellent Good Fair Poor

Yes No Is saving your teeth important to you? If so, why?

____

Yes No Does having dental treatment make your child afraid or nervous? If yes, what specific things bothers your child?

____

Please circle the following which are important to you when making your child's dental health decision.

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology

Parent Signature: ____ Date: ____________________