

DENTAL HISTORY OF CHILD OR TEENAGER

Patient's Name _____ Nickname _____ Date of Birth _____
Name of former dentist _____ City _____
Has any member of your family been a patient of this office or our other office before: Yes ___ No ___
Name(s) _____
Present dental problems as you see it (if any) _____
Has your child had any past bad dental experiences? Explain _____
Oral hygiene procedures (e.g. self-brushing, parental help, flossing) _____
History of traumatic injury of teeth _____

I authorize routine dental diagnostic procedures for my child. I also agree to the use of anesthetics considered necessary and advisable by the dentist for the comfort and well-being of the child.

Parent or Legal Guardian _____ Date _____ 20 _____

MEDICAL HISTORY OF CHILD OR TEENAGER

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

- 1. Is your child in good health?..... Yes No
- 2. Have there been any changes in the child's general health within the past year? Yes No
- 3. The last physical examination was in _____
- 4. Is your child now under the care of a physician?..... Yes No
 If so, what is the condition being treated? _____
- 5. The name and address of the physician is _____
- 6. Has your child had any serious illness or operation?..... Yes No
 If so, what was the illness or operation? _____
- 7. Has your child been hospitalized or had a serious illness or operation within the past five (5) years? Yes No
 If so, what was the problem? _____
- 8. Has the child had any of the following diseases or problems?
 - a. Congenital birth defect Yes No
 If so, please explain _____
 - b. Rheumatic fever or rheumatic heart disease Yes No
 - c. Congenital heart lesions Yes No
 - d. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, Coronary occlusion, high or low blood pressure, heart murmur) Yes No
 - e. Allergy Yes No
 - f. Sinus trouble Yes No
 - g. Asthma or hay fever Yes No
 - h. Hives or a skin rash Yes No
 - i. Fainting spells or seizures Yes No
 - j. Diabetes Yes No
 1) Does your child have to urinate (pass water) more than six times a day? Yes No
 2) Is your child thirsty much of the time? Yes No
 - k. Hepatitis, jaundice or liver disease Yes No
 - l. Arthritis Yes No
 - m. Inflammatory rheumatism (painful swollen joints) Yes No
 - n. Stomach ulcers Yes No
 - o. Kidney trouble Yes No
 - p. Tuberculosis Yes No
 - q. Is there a persistent cough or coughing up of blood Yes No
 - r. Venereal disease Yes No
 - s. Auto Immune Disease Yes No
 - t. Recurrent/Frequency of headaches Yes No
 - u. Other Yes No
- 8. Is there any blood disorder such as anemia? Yes No

9. Has the child had surgery or X-ray treatment for a tumor, growth, or other condition? Yes No
10. Has your child had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
 a. Does your child bruise easily? Yes No
 b. Has your child ever required a blood transfusion? Yes No
 If so, explain the circumstances _____
11. Is your child taking any drugs or medicines? Yes No
 If so, what? _____
12. Are any of the following drugs routinely used?
 a. Antibiotics or sulfa drugs Yes No
 b. Anticoagulants (blood thinners) Yes No
 c. Cortisone (steroids) Yes No
 d. Tranquilizers Yes No
 e. Antihistamines Yes No
 f. Aspirin Yes No
 g. Insulin, Tolbutamide (Orinase) or similar drug Yes No
 h. Digitalis or drugs for heart trouble Yes No
 i. Nitroglycerin Yes No
 j. Ritalin Yes No
 k. Other Yes No
13. Is your child allergic or had reacted adversely to:
 a. Local anesthetics? Yes No
 b. Penicillin or other antibiotics? Yes No
 c. Sulfa drugs? Yes No
 d. Barbiturates, sedatives, or sleeping pills? Yes No
 e. Aspirin? Yes No
 f. Codeine or other narcotics? Yes No
 g. Latex? Yes No
 h. Other? Yes No
14. Does your child have any mental and/or physical developmental delays? Yes No
15. Does your child have any behavior/learning problem? Yes No
16. Does your child have any medical condition not listed above? Yes No
 If so, explain _____
17. Does your child have any special problem? Yes No
 If so, explain _____

_____ Date _____ 20 _____

SIGNATURE OF PARENT/LEGAL GUARDIAN

PATIENT RESUME:

MEDICAL ALERT:

HOSPITALIZATIONS:

SURGERIES:

MEDICATIONS:

ALLERGIES:

SEDATION CLEARANCE:

_____ Date _____ 20 _____

SIGNATURE OF DENTIST