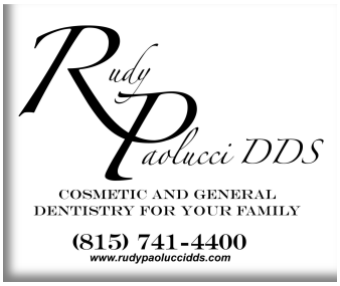
Child Medical/Dental History

Date:_____



Child's Name:_____ Nickname:_____

Date of Birth:_____ Sex: M____ F____

Parent's/Guardian's name:_____ Relationship:_____

Address:_____

Phone: Home_____ Mobile_____ Preferred_____

Has your child ever had any of the following	Yes	No
Heart Murmur or congenital Heart Disease (circle)_____	___	___
Asthma, Cystic Fibrosis, Respiratory Disease (circle)_____	___	___
Diabetes, Thyroid, Endocrine disease (circle)_____	___	___
Liver Disease_____	___	___
Kidney Disease_____	___	___
Rheumatic Fever_____	___	___
Seizures/convulsions/Loss of Consciousness (circle)_____	___	___
HIV_____	___	___
Anemia, Hemophilia, other Blood Disorder (circle)_____	___	___
Cancer_____	___	___
Speech, Hearing or Vision Disorder (circle)_____	___	___
Frequent Headaches_____	___	___
Mental, Emotional, or Developmental concerns (circle)_____	___	___
Frequent infections_____	___	___

	Yes	No		
Has your child ever been hospitalized?_____	___	___	When?_____	Why?_____
Has your child ever been seriously ill?_____	___	___	When? _____	Explain:_____
Has your child ever had a significant injury?_____	___	___	When? _____	Explain:_____
Has your child ever had surgery?_____	___	___	When? _____	Explain:_____

Have you been told that your child should take a **prophylactic antibiotic** before dental work? N__ Y__ Explain_____

Which **medications** is your child taking? List_____

Does your child have any **allergies to medications?** List_____

Does your child have any allergies to foods, environment, other? List_____

Is there any other disease, medical condition or concern that we should be aware of in order to care for child? N___ Y____
If Yes explain:_____

Who is your child's Primary Physician? Name:_____ Telephone:_____

Has your child ever had any of the following	Yes	No	
Pain in teeth _____	___	___	
Swelling of the mouth and face _____	___	___	
Injury to the face or teeth_____	___	___	
A bad dental experience _____	___	___	Explain:_____
Does your water have fluoride _____	___	___	
Does/did your child suck their thumb?_____	___	___	
Does your child grind their teeth?_____	___	___	
Does your child have any dental concerns?__	___	___	Explain:_____
			_____
Are your child's teeth flossed daily?	___	___	

How often does your child brush their teeth? _____

_____
Parent/Guardian Signature