This medical history form is for ONE patient . Each individual patient must have his/her own medical history form.

Dental History

Date _____

Child's Name _____

Date of last visit to dentist?_____ For what service? _____

Previous Dentist's name?_____ Were X-rays taken at previous dental visit? _____

Has child complained about dental problems?	Y N	Dental concerns: _____		
Does child brush teeth daily?	Y N	Any injuries to mouth, teeth, head?	Y N	
Does child use floss daily?	Y N	Is fluoride taken in any form?	Y N	
Any unhappy dental experiences?	Y N	Please list details: _____		

_____

Any mouth habits—thumb sucking, nail biting, pacifier, sleeping with bottle, etc? _____
Does your child participate in any sports?_____ Does your child wear a mouthguard? _____
Has your child ever had orthodontic treatment? _____ When? _____ Orthodontist? _____
Does your child have a special/restricted diet? _____
How often does your child have the following?

Bottles at bed	Never	Sometimes	Regularly	Often
Candy/Sweet treats	Never	Sometimes	Regularly	Often
Soft drinks/Juices	Never	Sometimes	Regularly	Often
Snacks Between Meals	Never	Sometimes	Regularly	Often

Health History

Y N Abnormal bleeding
Y N Allergies to drugs
Y N Allergies to latex
Y N Any hospital stays
Y N Any surgery
Y N Anemia
Y N Asthma
Y N Autism
Y N Emotional or psychiatric issues
Y N Cancer

Y N Convulsions/Epilepsy
Y N Cystic fibrosis
Y N Developmental Disorders
Y N Diabetes
Y N Excessive Gag Reflex
Y N Handicaps/Disabilities
Y N Heart Problems
Y N Hepatitis
Y N HIV/AIDS
Y N Impaired vision, hearing or speech

Y N Kidney Disease
Y N Limited Use of Limbs
Y N Liver Disease
Y N Measles
Y N Mononucleosis
Y N Mumps
Y N Pregnancy
Y N Rheumatic Scarlet Fever
Y N Thyroid disease
Y N Tuberculoses

Please discuss any serious medical conditions the child has had_____
_____

Please list all drugs child is currently taking _____
_____

Please list all drugs the child is allergic to_____

Is your child under the care of a Physician? Yes No

Child's Physician _____Phone (____)_____

Please describe your child's current physical health Poor Fair Good