Welcome _____ Age _____ Date _____

Med Alert

Patient's Name _____ Date of Birth / / **q** Female **q** Male

Last First M. Initial

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER
PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

COMMENTS

Dental History

1. Is this your child's first visit to the dentist?: _____ YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? _____ YES NO
4. Does your child eat between meals? _____ YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? _____ YES NO
6. When does your child brush his/her teeth?
   q Upon arising **q** After eating any food **q** Right after meals **q** before going to bed
7. How does your child receive Fluoride?
   q Community Water level ____ ppm **q** Well Water level ___ ppm
   q Fluoride drops or tablets **q** Fluoride rinse or gel
8. Have any cavities been noted in the past? _____ YES NO
9. Were any teeth (baby or permanent) removed by extraction _____ YES NO
   Was it suggested that the space be maintained _____ YES NO
   Was an appliance placed _____ YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc? _____ YES NO
11. Has your child had any problem with dental treatment in the past _____ YES NO
12. Has anyone in the family, including parents, had orthodontics? _____ YES NO
13. Has your child ever received a local anesthetic? _____ YES NO
14. Has your child ever had occlusal sealants? _____ YES NO
15. Does your child think there is anything wrong with his/her teeth? _____ YES NO

Medical History

1. Does your child have a health problem? _____ YES NO
2. Is your child under care of a physician? _____ YES NO
   IF YES, since when and why? _____
   Name of Physician _____
3. Is your child receiving any medication? _____ YES NO
   IF YES, what king? _____
4. is your child allergic to penicillin, antibiotics or other drugs? _____ YES NO
5. Is your child allergic to or sensitive to any metals or latex? _____ YES NO
6. Does your child have other allergies? _____ YES NO
7. Has your child had any serious illness? _____ YES NO
   WHEN? _____ WHAT? _____
8. Has your child ever had surgery? _____ YES NO
9. Does your child have a Heart Murmur? _____ YES NO
10. Is surgery contemplated? _____ YES NO
11. Does your child experience severe or prolonged bleeding _____ YES NO
12. Does your child have AIDS or has he/she tested HIV positive? _____ YES NO
13. Has your child tested positive for hepatitis? _____ YES NO
14. Is your child subject to nervous disorders? _____ YES NO
    q Fainting? **q** Seizures? **q** Dizziness? **q** Behavioral/Learning problems?
15. Does your child have frequent headaches? _____ YES NO
16. Has your child had history of : (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, Rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, Eyesight problems, cancer, infections, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/ GUARDIAN'S SIGNATURE: _____ DATE _____

DENTIST SIGNATURE: _____ DATE _____

CHILD DENTAL MEDICAL HISTORY

Advanced Dental Care
Gentle modern care for your health and smile