Children's Dental Care, P. C.

Children's Dental Care Medical History(Copy)(Copy)(Copy)

Patient Name: Birth Date: Date Created:

DENTAL HISTORY

Is this the patient's first visit to a dentist? ◯ Yes ◯ No

When was the patient's last dental visit? Were the teeth cleaned at that time? ◯ Yes ◯ No If yes

Does the patient eat between meals? ◯ Yes ◯ No

Does the patient eat well balanced meals? ◯ Yes ◯ No

Does the patient eat or drink the following foods?

candy	◯ Yes ◯ No	soda pop	◯ Yes ◯ No	fruit juice	◯ Yes ◯ No	chewing gum	◯ Yes ◯ No
flavored milk	◯ Yes ◯ No	chewy fruit flavored snacks	◯ Yes ◯ No				

Have any cavities been noted in the past? ◯ Yes ◯ No

Has the patient ever been treated with fluoride? ◯ Yes ◯ No

Is there fluoride in the patient's drinking water? ◯ Yes ◯ No

Is there a family history of cavities? ◯ Yes ◯ No

Has there been any injuries to the patient's mouth involving the teeth? ◯ Yes ◯ No If yes

Has the patient ever had sealants placed on any teeth? (If "yes", at what dental office and date of application) ◯ Yes ◯ No If yes

When does the patient brush their teeth?

Before school	◯ Yes	◯ No
After eating meals or snacks	◯ Yes	◯ No
Before going to bed	◯ Yes	◯ No

MEDICAL HISTORY

Is the patient in good health? ◯ Yes ◯ No

Does the patient see primary care physician? (If "yes" please give us the physician's name) ◯ Yes ◯ No If yes

Is the patient is taking any medications? (If "yes" please list all of them) ◯ Yes ◯ No If yes

Has the patient had any serious illness? (if "yes", please indicate what type of illness and when the illness occurred) ◯ Yes ◯ No If yes

Does patient have any allergies? (If "yes", list all) ◯ Yes ◯ No If yes

Has the patient ever had surgery? (if "yes", please indicate what type of surgery/name of doctor and date) ◯ Yes ◯ No If yes

Is there a surgery contemplated in the future? (If "yes" please describe-type of surgery/name of doctor and date) ◯ Yes ◯ No If yes

Does the patient smoke, chew, use snuff or any other forms of tobacco? (Describe) ◯ Yes ◯ No If yes

Does the patient have a heart condition? (If "yes", Name of cardiologist/year of diagnosis and is prophylaxsis necessary ◯ Yes ◯ No If yes

Does the patient take birth control medication? Is the patient pregnant or is there suspicion of pregnancy? ◯ Yes ◯ No If yes

Has the patient tested positive or been diagnosed with any of the following?

Diabetes	◯ Yes ◯ No	Heart Disease/Trouble	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Tooth Ache	◯ Yes ◯ No
Ear Infection	◯ Yes ◯ No	Down's Syndrome	◯ Yes ◯ No	Autism	◯ Yes ◯ No
ADD (Attention Deficit Disorder)	◯ Yes ◯ No	ADHD (Attention Deficit Hyper Disorder)	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Artificial Joints/Prothesis	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Epilesy or Seizure Disorder	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Orthopedic Surgery/Ortho Hardware	◯ Yes ◯ No
AIDS/HIV positive	◯ Yes ◯ No	Hepatitis A, B or C	◯ Yes ◯ No	T.B. (Tuberculosis)	◯ Yes ◯ No
Dizziness/Fainting	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No	Blood Disorder	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No		

Is there anything else we should know about the patient's health not covered in this form? ◯ Yes ◯ No If yes

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signature of Parent or Guardian:

X

Date:_____