

Medical / Dental History

Has your child had any of the following medical or dental conditions/problems? Please mark the appropriate answers and fill in the blanks.

Medical History

Yes No ADD ADHD Autism
 Yes No Sensory Issues

Yes No Allergy to drugs
 If Yes, List: _____

Yes No Allergy to latex
 Yes No Anxiety
 Yes No Asthma
 Yes No Bleeding disorders of concerns
 Yes No Bone/Joint problems
 Yes No Cancer
 Yes No Depression
 Yes No Diabetes
 Yes No Disabilities/ Handicaps
 If Yes, Explain: _____

Yes No Eating Disorder
 Please specify: _____

Yes No Epilepsy/Convulsions
 Yes No Genetic disorders
 If Yes, Explain: _____

Yes No Hepatitis
 Yes No Heart murmur
 Yes No Heart problems
 If Yes, List: _____

Yes No Premedication for dental work
 Yes No Hearing problems
 If Yes, Explain: _____

Yes No Hemophilia
 Yes No HIV/Aids
 Yes No Hospitalizations
 If Yes, Explain: _____

Yes No Surgeries
 If Yes Explain: _____

Yes No Kidney/Liver problems
 Yes No Rheumatic fever
 Yes No Tuberculosis
 Yes No Vision problems
 ___ Glasses ___ Contacts
 Other _____

Yes No If you answered yes to any of these questions, please provide additional information here:

Dental History

Yes No Abscesses (gum boils)
 Yes No Bleeding gums
 Yes No Clenching or grinding habit
 Yes No Fluoridated water
 Yes No Fluoride rinses/ Supplements
 Yes No Frequent mouth sores
 Yes No Injuries to jaw or teeth
 Yes No Lip/tongue biting habit
 Yes No Teeth brushed daily
 Yes No Teeth flossed daily
 Yes No Thumb/finger sucking habit
 Yes No Toothaches
 If Yes, Explain: _____

Yes No First visit to dentist
 (if no, date of last visit)

Yes No Problems associated with
 previous dental visits (list)

Current medications (list) _____

Other dental problems or conditions (specify) _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held to the strictest confidence, and it is my responsibility to inform the office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.