



# Children 12 & Under Medical and Dental History

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Emergency Contact (Name/Phone #) \_\_\_\_\_

## Medical History

1. Does your child have any current health problems? .....  Yes  No  
If yes, please explain: \_\_\_\_\_

2. Is your child under care of a physician? .....  Yes  No  
Name of physician: \_\_\_\_\_

3. Is your child receiving any prescriptions, herbal, or OTC medications? .....  Yes  No  
If yes, what and when? \_\_\_\_\_

4. Has your child had any serious illness? .....  Yes  No  
If yes, what and when? \_\_\_\_\_

5. Has your child ever had surgery or is surgery contemplated? .....  Yes  No  
If yes, please explain: \_\_\_\_\_

6. Does your child have a heart murmur or any other heart conditions? .....  Yes  No

7. Does your child experience severe or prolonged bleeding? .....  Yes  No  
If yes, please explain: \_\_\_\_\_

8. Does your child have AIDS or has he/she tested HIV positive? .....  Yes  No

9. Has your child tested positive for hepatitis? .....  Yes  No

10. Has your child had a history of nervous disorders? .....  Yes  No

11. Does your child have frequent headaches? .....  Yes  No  
If yes, please explain: \_\_\_\_\_

12. Is your child allergic/sensitive to: None Codeine Penicillin Local Anesthetic Latex Pine Nuts  
Dyes Other: \_\_\_\_\_

13. Does your child have or ever had:

ADD/ADHD	..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis/jaundice	..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalizations	..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Autism	..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney infection	..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioural problems	..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver problems	..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia/Lymphoma	..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebral palsy	..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Oral herpetic lesions	..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental delay	..... <input type="checkbox"/> Yes <input type="checkbox"/> No	School problems	..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Speech impairments	..... <input type="checkbox"/> Yes <input type="checkbox"/> No

Epilepsy/seizures/fainting ..... Yes No  
Eating disorders ..... Yes No  
Hay fever/seasonal allergies ..... Yes No  
Hearing impaired ..... Yes No

Thyroid problems ..... Yes No  
Rheumatic fever ..... Yes No  
Take pre-medication for anything?..... Yes No  
If yes, please explain? \_\_\_\_\_  
\_\_\_\_\_

## Dental History

1. This is my child's first visit to the dentist ..... Yes No  
2. When does your child brush his/her teeth?  
After Waking Up After any food Right after meals Before bedtime  
3. Do you currently monitor your child's sugar intake in food, snacks, and drinks? ..... Yes No  
4. Does your child receive Fluoride in their drinking water? ..... Yes No  
5. Does your child receive supplemental Fluoride at home? ..... Yes No  
6. Have any cavities been noted in the past? ..... Yes No  
7. Does your child suck his/her thumb or fingers? ..... Yes No  
8. Were any teeth (baby or permanent) removed by extraction? ..... Yes No  
9. Has a space maintainer been recommended? ..... Yes No  
10. Has a space maintainer been placed? ..... 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  
If yes, when? \_\_\_\_\_  
15. Does your child think there is anything wrong with his/her teeth?..... Yes No  
16. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... Yes No  
17. Does your child grind, clench, or brux their teeth? ..... Yes No  
Please explain: \_\_\_\_\_  
18. Does your child snore? ..... Yes No  
19. Is there anything else that would be valuable for your dentist to know to best care for your child?... Yes No  
Please explain: \_\_\_\_\_

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my child's healthcare, advice, and treatment provided for the purpose of improved treatment outcomes and/or evaluating and administering claims for insurance benefits.
- I attest to the accuracy of the information on this page and understand that it is my responsibility to inform the Doctor and the office staff of any changes in my child's medical status at the very next appointment, before any further treatment is rendered.

Patient's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_