Name:_____ Date:_____

COMMENTS *(For office use only)*

Med. Alert

MEDICAL HISTORY

1. Is your child under care of a physician?_____ ☐ Yes ☐ No
   If yes, since when and why?_____
2. Name of physician _____
3. Is your child receiving any medication?_____ ☐ Yes ☐ No
   List current medications _____
4. Is your child allergic to any drugs, such as penicillin?_____ ☐ Yes ☐ No
5. Dos your child have other allergies? _____ ☐ Yes ☐ No
6. Has your child had any serious illness? _____ ☐ Yes ☐ No
7. Has your child ever been hospitalized or had surgery? _____ ☐ Yes ☐ No
8. Has your child had a history of any of the following? **Please check a response for each question:**

Heart trouble, murmur, or heart surgery _____ ☐ Yes ☐ No
Rheumatic fever or scarlet fever _____ ☐ Yes ☐ No
Asthma, TB, or lung problems _____ ☐ Yes ☐ No
HIV infection or AIDS _____ ☐ Yes ☐ No
Hemophilia or bleeding problems _____ ☐ Yes ☐ No
Sickle cell anemia/blood disorder _____ ☐ Yes ☐ No
Hepatitis or liver problems _____ ☐ Yes ☐ No
Kidney infection _____ ☐ Yes ☐ No
Diabetes _____ ☐ Yes ☐ No
Cancer, tumor, leukemia _____ ☐ Yes ☐ No
Thyroid or other glandular problems _____ ☐ Yes ☐ No
Latex or rubber allergy _____ ☐ Yes ☐ No
Epilepsy, seizures, fainting _____ ☐ Yes ☐ No
Cerebral palsy or development delay _____ ☐ Yes ☐ No
Vision problems _____ ☐ Yes ☐ No
Speech or hearing problems _____ ☐ Yes ☐ No
Emotional or psychological problems _____ ☐ Yes ☐ No
Congenital birth defects _____ ☐ Yes ☐ No
Cleft lip or palate _____ ☐ Yes ☐ No
Malignant hyperthermia _____ ☐ Yes ☐ No
Other medical condition _____ ☐ Yes ☐ No
Is parent or patient pregnant? _____ ☐ Yes ☐ No

PURPOSE OF TODAY'S VISIT _____

DENTAL HISTORY

1. When and where was your child's last dental visit?_____
2. What was the purpose of that visit? _____
3. Were any x-rays taken at your child's last dental visit? _____ ☐ Yes ☐ No
4. Did your child have difficulty cooperating? ___ ☐ Yes ☐ No
5. Was/is your child bottle fed?_____ ☐ Yes ☐ No
6. Was/is your child breast fed?_____ ☐ Yes ☐ No
7. If your child has been weaned please indicate at what age: _____
8. When does your child brush his/her teeth?
   ☐ Upon arising ☐ After eating any food
   ☐ Right after meals ☐ Before going to bed
9. Do you assist/supervise your child's brushing? __ ☐ Yes ☐ No
10. Does your child take fluoride supplements?_____ ☐ Yes ☐ No
11. Have any cavities been noted in the past?_____ ☐ Yes ☐ No
12. Were any teeth (baby or permanent) removed by extraction? _____ ☐ Yes ☐ No
13. Have there been any injuries to teeth, such as falls, blows, chips, etc.?_____ ☐ Yes ☐ No
14. Has anyone in the family, including parents, had orthodontics? _____ ☐ Yes ☐ No
15. Has your child had a toothache recently? _____ ☐ Yes ☐ No
    If yes, explain:_____
16. Do you expect your child to be cooperative? ____ ☐ Yes ☐ No
17. Does your child have other siblings seen by us?__ ☐ Yes ☐ No

CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. Johnson and his staff to perform such treatments, services, medication, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

_____

Signature **Date**

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