PECAN PARK FAMILY DENTISTRY

CHILD MEDICAL/DENTAL HISTORY FORM

Patient Name____ **DOB** ________________ **Date** ________________

Guardian's Name ______________________________________ **Relationship to Patient:** ______________________

MEDICAL HISTORY

Physician's Name ____ Phone No.___________________________

Date of most recent exam ____________________________ Purpose of visit __________________________________

	YES	NO
Does your child have any health problems? ____________________	O	O
Does your child have any allergies to any medications (ie penicillin) or latex?__________	O	O
Does your child have any other allergies? ____________________	O	O
If so, please list: ______________________________		
Has your child ever had a serious illness or been hospitalized? ____________	O	O
Has your child ever had surgery or are any surgeries planned? ____________	O	O
Is your child taking any prescribed or over-the-counter medications? ____________	O	O
If so, please list: ______________________________		

Does your child have a history of any of the following? (Please circle all that apply.)

Asthma	Hepatitis	Mental Retardation
Heart Problems	AIDS/HIV	Eye Problems
Liver Problems	Fainting/Dizziness	Speech Impairments
Kidney Problems/Infections	Seizures/Epilepsy	Hearing Loss
Lung Problems	Behavioral/Learning Disorders	Infections
Diabetes	Rheumatic Fever	Tuberculosis
Heart Murmur	Cerebral Palsy	Nervous Disorders
Prolonged/Severe Bleeding	Congenital Birth Defects	Growth Problems

DENTAL HISTORY

	YES	NO
Is this your child's first dental visit? If not, when was the last visit? ____________	O	O
Has your child ever had an unfavorable dental experience?____________	O	O
Has your child ever received local anesthetic? ____________	O	O
Does your child eat between meals? ____________	O	O
Has your child had protective sealants placed on his/her teeth? ____________	O	O

Does your child: brush upon rising? ______________ brush after any meal? _____________

right after meals? _______________ before going to bed? ______________

Has your child ever suffered any injuries to the head, mouth, or neck? ____________	O	O
Has your child ever had any teeth extracted (baby or adult)?____________	O	O
Has your child had cavities diagnosed in the past?____________	O	O
Does your child use toothpaste containing fluoride?____________	O	O

What type of water does your child drink? O City O Well O Bottled O Filtered

Please list any concerns that you have about your child's dental health. ____

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I certify that the above information is complete and correct.

Patient's (Guardian's) signature:____ Date:__________________

Doctor's signature:____ Date:_____________________