Medical & Dental History

0-12 Years Chart #_____

Child's first &Last name:_____

Nick name if any:_____Child's Primary language:_____

Age:_____ Date of Birth:_____ Sex: ☐ Female ☐ Male

Purpose for you visit?_____

Is your child receiving dental care? ☐ Yes ☐ No

Has your child had any unpleasant experience with a dentist in the past? ☐ Yes ☐ No

Attitude towards Dentistry: ☐ Normal ☐ Shy ☐ Apprehensive ☐ frightened

Any injuries to mouth, teeth, head? ☐ Yes ☐ No

Any habits such as: thumb sucking, nail biting, mouth breathing, nursing, bottle, pacifier, ect? ☐ yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No

How many times a day?_____

Do you assist with tooth brushing? ☐ Yes ☐ No

Does your child floss? ☐ Yes ☐ No

Are his/her teeth sensitive to: ☐ hot ☐ cold ☐ sweets ☐ pressure

Medical History

Is your child under the care of a physician now? If yes please explain; ☐ Yes ☐ No

---

Is your child taking any medications? If yes, please list them; ☐ Yes ☐ No

---

Are his/ her vaccinations up to date? ☐ Yes ☐ No

Has your child ever had a blood transfusion? If yes please explain; ☐ yes ☐ No

---

Any allergies/ sensitivities/ adverse reactions to any drugs or medication (penicillin, anesthetic, ect)?_____

Allergies to any substance (latex, nickel, etc.)?_____

Does your Child have or had any of the following conditions:

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Cerebral	☐	☐	Depression/Anxiety	☐	☐
Diabetes	☐	☐	Liver Disease	☐	☐	Disabilities/Handicap	☐	☐
Asthma	☐	☐	Tuberculosis	☐	☐	Congenital Heart defect	☐	☐
Fainting	☐	☐	Convulsions	☐	☐	Hearing loss/ impairment	☐	☐
Cancer	☐	☐	Heart Conditions	☐	☐	Hemophilia/ bleeding disorder	☐	☐
ADHD/ADD	☐	☐	Kidney Disease	☐	☐	Other: _____	☐	☐
HIV/AID	☐	☐	Bleeding Problems	☐	☐			
Epilepsy	☐	☐	Chronic Sinus	☐	☐			
Hepatitis	☐	☐	Rheumatic fever	☐	☐			

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I have given permission to the dentist to obtain from my physician any additional information regarding my medical or dental history needed to provide me the best dental treatment possible.

Signature of parent or legal Guardian_____Date:_____

Relationship to patient:_____