MEDICAL HISTORY - CHILD

Name______________________________________

List any drug or medicine allergies____
List drugs or medicine presently being taken_____________________________________
Is child under care of a physician now? Y N Reason____________________________
Has child ever been hospitalized? Y N Reason_______________________________

Has child any history of/or difficulty with any of the following? If yes, explain

Anemia___________________________________
Asthma___________________________________
Bladder___________________________________
Cerebral Palsy______________________________
Chicken Pox________________________________
Rheumatic Fever_____________________________
Chronic sinus_______________________________
Convulsions________________________________
Diabetes__________________________________
Epilepsy__________________________________
Fainting__________________________________
Hearing________________________
Heart___________________________
Liver___________________________
Malignancies_____________________
Thyroid_________________________
Kidney__________________________
Mastoid_________________________
Measles_________________________
Mononucleosis____________________
Mumps__________________________
Tuberculosis______________________
Other____

Is child presently experiencing a dental problem Y N Explain____________________
Date of last dental visit____________ For what services?__________________________

Please circle

Y	N	Has child had any unhappy dental experiences
Y	N	Any injuries to mouth, teeth or head
Y	N	Any mouth habits (thumbsucking, nail biting, mouth breather, bottle habits pacifier, etc.) please circle
Y	N	Any unusual speech habits? If yes, explain__________________________
Y	N	Orthodontic appliances worn now or ever
Y	N	Does your child brush his/her teeth daily
Y	N	Do you assist your child with tooth brushing
Y	N	Is dental floss used
Y	N	Is fluoride taken in any form If yes, how____________________________

What is child's favorite sport/hobby?____

Signature__________________________________ Date____________________________
Reviewed:
Initial_______ Date_______ Initial________Date_______ Initial_______Date_______