

MEDICAL HISTORY FOR:

MO	DAY	YR
----	-----	----

**MEDIC
ALERT**

The following information is required by the dentist to assist in proper diagnosis and treatment. ALL INFORMATION IS CONFIDENTIAL.

		Yes	No
1.	Has the child had an illness requiring hospitalization or medical care? Why? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is the child presently under the care of a physician? Why? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has the child had a medical examination in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Does the child use any prescription or non-prescription medicine regularly? Why? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Does the child have any allergic conditions? Specify: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Has the child been hospitalized in the last 2 years? Why? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Has the child ever experienced any reaction to any of the following? <input type="checkbox"/> Local anaesthesia (freezing) <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfonamide (sulfa) <input type="checkbox"/> or any other medicine Explain: <input type="text"/>		
8.	Has the child been warned against taking any drug or medication?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Does the child have, or ever had, any of the following? <input type="checkbox"/> Heart murmur or heart condition <input type="checkbox"/> Lung disease <input type="checkbox"/> Kidney disease <input type="checkbox"/> Stomach/intestinal problems <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Thumb sucking <input type="checkbox"/> Hyper (hypo) glycemia <input type="checkbox"/> AIDS <input type="checkbox"/> Gum chewing <input type="checkbox"/> Epilepsy or seizures <input type="checkbox"/> Jaundice <input type="checkbox"/> Past or current soother habits <input type="checkbox"/> Arthritis or rheumatism <input type="checkbox"/> Diabetes <input type="checkbox"/> Other <input type="checkbox"/> Scarlet or rheumatic fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis A B C <input type="checkbox"/> Cancer		
10.	Has the child ever had any known contact with the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has any member of the family had diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Does the child bruise easily or bleed abnormally?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has the child ever had radiation treatment or chemotherapy? Explain: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Has the child ever had an injury, surgery, or X-ray therapy to their face or jaws?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Does the child have frequent earaches, ear/throat infections, or hearing difficulty?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Is the child on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Has the child ever fainted?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Has the child had any organ transplants or medical implants?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Does the child have any disease, condition or problem not listed above that you think the doctor should know about? Explain: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Is there anything about this child that we should be made aware of? Explain: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

DENTAL HEALTH QUESTIONNAIRE FOR:

MO	DAY	YR
----	-----	----

A child's dental health is affected by many different things. The three most important to developing teeth are home dental care (brushing, flossing, and the use of fluoride), any habits relating to the mouth and teeth, and your child's diet. To help us better evaluate your child's dental health, please answer the following questions:

		Yes	No
HABITS			
1.	Did/does your child suck his/her thumb or finger?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Does your child chew ice?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Does your child grind his/her teeth?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Does your child have any other tooth-related habits?	<input type="checkbox"/>	<input type="checkbox"/>
HOME DENTAL CARE			
1.	Does your child brush his/her own teeth? How often? <input type="text"/> times per day <input type="text"/> times per week	<input type="checkbox"/>	<input type="checkbox"/>
2.	How much toothpaste does your child use? <input type="text"/>		
3.	Does your child use dental floss? How often? <input type="text"/> times per day <input type="text"/> times per week	<input type="checkbox"/>	<input type="checkbox"/>
4.	Does your child use a fluoride mouthwash? If yes, at school? <input type="checkbox"/> at home <input type="checkbox"/> Brand name: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you brush your child's teeth? How often? <input type="text"/> times per day <input type="text"/> times per week	<input type="checkbox"/>	<input type="checkbox"/>
6.	Does your child swallow toothpaste?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you floss your child's teeth? How often? <input type="text"/> times per day <input type="text"/> times per week	<input type="checkbox"/>	<input type="checkbox"/>
8.	Has your child ever lived in a fluoridated area? If yes, at what age? <input type="text"/> How long? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has your child received fluoride treatments at a dental office?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Anything else you would like to add about the care of your child's teeth at home? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIET			
1.	How many meals per day does your child eat? <input type="text"/>		
2.	How many between meal snacks (including drinks other than water) does your child have on an average day? <input type="text"/>		
3.	Does your child chew gum with sugar in it? If yes, how often? <input type="text"/> times per day <input type="text"/> times per week	<input type="checkbox"/>	<input type="checkbox"/>
4.	Does your child have <input type="checkbox"/> raisins, <input type="checkbox"/> fruit rollups, <input type="checkbox"/> fruit wrinkles, <input type="checkbox"/> candy in small pieces, <input type="checkbox"/> breath mints, or <input type="checkbox"/> suckers?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Does your child consume sport drinks?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Would you like to make any comments about your child's diet? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
DENTAL HISTORY			
1.	Has your child ever had a bad experience with dental care? Explain: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last dental visit: <input type="text"/>		Last full mouth series of X-rays: <input type="text"/>	
Comments: <input type="text"/>			

INFORMED CONSENT/GENERAL RELEASE (Please sign after completing medical questionnaire)

I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical/dental history. **Should there be any change in either my health or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility of payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Patient (parent, guardian) signature:

If parent, guardian*, please print name:

Reviewed by Treating Dentist:

Date (mm/dd/yyyy):