STRATHROY DENTAL CENTRE

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?	☐	☐
2.	Is the child presently under the care of a physician? Why?	☐	☐
3.	Has the child had a medical examination in the last year?	☐	☐
4.	Does the child use any prescription or non-prescription medicine regularly? Why?	☐	☐
5.	Does the child have any allergic conditions? Specify:	☐	☐
6.	Has the child been hospitalized in the last 2 years? Why?	☐	☐
7.	Has the child ever experienced any reaction to any of the following? ☐ Local anaesthesia (freezing) ☐ Penicillin ☐ Sulfonamide (sulfa) ☐ or any other medicine Explain:		
8.	Has the child been warned against taking any drug or medication?	☐	☐
9.	Does the child have,or ever had, any of the following? ☐ Heart murmur or heart condition ☐ Lung disease ☐ Kidney disease ☐ Stomach/intestinal problems ☐ Thyroid disease ☐ Thumb sucking ☐ Hyper (hypo) glycemia ☐ AIDS ☐ Gum chewing ☐ Epilepsy or seizures ☐ Jaundice ☐ Past or current soother habits ☐ Arthritis or rheumatism ☐ Diabetes ☐ Other ☐ Scarlet or rheumatic fever ☐ Tuberculosis ☐ Hepatitis A B C ☐ Cancer		
10.	Has the child ever had any known contact with the AIDS virus?	☐	☐
11.	Has any member of the family had diabetes?	☐	☐
12.	Does the child bruise easily or bleed abnormally?	☐	☐
13.	Has the child ever had radiation treatment or chemotherapy? Explain:	☐	☐
14.	Has the child ever had an injury, surgery, or X-ray therapy to their face or jaws?	☐	☐
15.	Does the child have frequent earaches, ear/throat infections, or hearing difficulty?	☐	☐
16.	Is the child on a special diet?	☐	☐
17.	Has the child ever fainted?	☐	☐
18.	Has the child had any organ transplants or medical implants?	☐	☐
19.	Does the child have any disease, condition or problem not listed above that you think the doctor should know about? Explain:	☐	☐
20.	Is there anything about this child that we should be made aware of? Explain:	☐	☐

TO AVOID COMPLICATIONS, PLEASE NOTIFY OUR OFFICE OF CHANGES IN THE CHILD'S MEDICAL CONDITION

STRATHROY DENTAL CENTRE

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?	☐	☐
2.	Does your child chew ice?	☐	☐
3.	Does your child grind his/her teeth?	☐	☐
4.	Does your child have any other tooth-related habits?	☐	☐
HOME DENTAL CARE			
1.	Does your child brush his/her own teeth? How often? ____ times per day ____ times per week	☐	☐
2.	How much toothpaste does your child use?		
3.	Does your child use dental floss? How often? ____ times per day ____ times per week	☐	☐
4.	Does your child use a fluoride mouthwash? If yes, at school? ☐ at home ☐ Brand name:	☐	☐
5.	Do you brush your child's teeth? How often? ____ times per day ____ times per week	☐	☐
6.	Does your child swallow toothpaste?	☐	☐
7.	Do you floss your child's teeth? How often? ____ times per day ____ times per week	☐	☐
8.	Has your child ever lived in a fluoridated area? If yes, at what age? How long?	☐	☐
9.	Has your child received fluoride treatments at a dental office?	☐	☐
10.	Anything else you would like to add about the care of your child's teeth at home?	☐	☐
DIET			
1.	Was/is your child put to bed with a bottle? If yes, what was in the bottle?	☐	☐
2.	Does your child chew gum with sugar in it? If yes, how often? ____ times per day ____ times per week	☐	☐
3.	How many between meal snacks, including drinks other than water, does your child have on an average day?		
4.	Was/is your child allowed to carry a bottle or cup throughout the day containing something other than plain water?	☐	☐
5.	How many meals per day does your child eat?		
6.	If your child is using a pacifier, is it ever dipped in honey or other sweet substances?	☐	☐
7.	Would you like to make any comments about your child's diet?	☐	☐
DENTAL HISTORY			
1.	Has your child ever had a bad experience with dental care? Explain:	☐	☐

Last dental visit: _____ Last full mouth series of X-rays: _____

Comments: _____

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): _____

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SUBMIT CLEAR FORM