CHILD DENTAL & MEDICAL HISTORY

DENTAL HISTORY

Doctor's Notes

1. Is this the child's first visit to a dentist?........ YES NO
If no, how long since the child's last visit? ____________
2. Does the child eat between meals?........ YES NO
3. Does the child eat sweets, such as candy, soda pop or chewing gum?........ YES NO
4. Does the child eat well-balanced meals?........ YES NO
5. Who brushes the child's teeth? ____________
How often? ____________
6. Do you live in an area without fluoridated water?........ YES NO
7. Have teeth been treated with fluorides?........ YES NO
8. Have any cavities been noted in the past?........ YES NO
9. Were any teeth (baby or permanent) removed by extraction?........ YES NO
Was it suggested that the space be maintained?........ YES NO
Was a space-maintaining appliance placed?........ YES NO
10. Have teeth suffered any traumas from falls or blows, etc.?........ YES NO
If so, please describe ____________
____
11. Has the child had any unfavorable dental experience?........ YES NO
12. Has anyone in the family, including parents, had braces?........ YES NO
13. Has the child ever received a local anesthetic?........ YES NO
14. Has the child ever had occlusal sealants (to prevent dental decay)?........ YES NO

MEDICAL HISTORY

1. Is the child in good health?........ YES NO
2. Is the child currently being treated/monitored for a specific condition by a physician?........ YES NO
If yes, how long and why? ____________
3. Name of the physician: ____________
Telephone: ( ) ____________
4. Has the child had any serious illness?........ YES NO
What? ____________
When? ____________
5. Has the child had surgery?........ YES NO
6. Is surgery being contemplated?........ YES NO
7. Is the child subject to profuse bleeding?........ YES NO
8. Is the child subject to nervous disorders?........ YES NO
9. Is the child subject to fainting or dizziness?........ YES NO
10. Does the child have any allergies?........ YES NO
11. Is the child allergic to penicillin, antibiotics or other drugs?........ YES NO
12. Is the child receiving any medication?........ YES NO
If yes, please list: ____________
13. Has the child ever been advised to be premedicated with antibiotics prior to dental treatment?........ YES NO
14. The child has had a history of (please check):

- ☐ Diabetes
- ☐ Heart Trouble
- ☐ Asthma
- ☐ Kidney Infection
- ☐ Rheumatic Fever
- ☐ Ear Infection

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of Responsible Person ____________ Date ____________

Dentist's Signature ____________ Date ____________

ANEST.

MED. ALERT