PATIENT'S NAME ______________________________________________
Last | First | Initial | Nickname | Date of Birth

PARENT'S/GUARDIAN'S NAME

**DENTAL HISTORY** - CIRCLE THE APPROPRIATE ANSWER YES NO **COMMENTS**

1. Is this your child's first visit to a dentist? ........................................................
2. If not, how long since the last visit to the dentist? ________________________
3. Were any x-rays or radiographs taken when your child previously visited the dentist? ........................................................................................
4. Does your child eat between meals? ........................................................
5. Does your child eat sweets, such as candy, soda pop, chewing gum? ..........
6. When does your child brush his/her teeth?
   ☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
7. How does your child receive Fluoride?
   ☐ Community water level ___ ppm ☐ Well water level ___ ppm
   ☐ Fluoride drops or tablets ☐ Fluoride rinse or gel
8. Have any cavities been noted in the past? ..................................................
9. Were any teeth (baby or permanent) removed by extraction? ......................
   Was it suggested that the space be maintained? ..........................................
   Was an appliance placed? ..............................................................................
10. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ........
    If so describe ______________________________________________
11. Has your child had any problem with dental treatment in the past? ...............
12. Has anyone in the family, including parents, had orthodontics? ....................
13. Has your child ever received a local anesthetic? ..........................................
14. Has your child ever had occlusal sealants? ..................................................
15. Does your child think there is anything wrong with his/her teeth? ..................

**MEDICAL HISTORY**

1. Does your child have a health problem? .......................................................
2. Is your child under care of physician? ...........................................................
   If yes, since when and why? ______________________________________
3. Name of physician Phone
   ______________________________________________________________
4. Is your child receiving any medication? .........................................................
   What? ______________________________________________________
5. Is your child allergic to penicillin, antibiotics or other drugs? .........................
6. Does your child have other allergies? ...........................................................
7. Has your child had any serious illness? .......................................................
   When ______________ What ______________________________
8. Has your child ever had surgery? ................................................................
9. Does your child have a heart murmur? ........................................................
10. Is surgery contemplated? ...........................................................................
11. Does your child experience severe or prolongated bleeding? .......................
12. Does your child have AIDS or has he/she tested HIV positive? ....................
13. Has your child tested positive for hepatitis? ................................................
14. Is your child subject to nervous disorders? ..................................................
    ☐ Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning problems?
15. Does your child have frequent headaches .................................................
16. Has your child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

*I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.*

PARENT'S/GUARDIAN'S SIGNATURE ______________________________ DATE ______________

DENTIST'S SIGNATURE ______________________________ DATE ______________

**ANEST.**

**MED. ALERT**

Form No. 131CDM

# CHILD DENTAL MEDICAL HISTORY