Medical/Dental History **today's date**_____

Child's primary care physican (Pediatrician) _____phone #_____
Date of last physical exam_____Is your child under doctor's care now?_____
For what reason_____
Has your child ever been hospitalized?_____ For what reason_____
Has your child received all immunizations?_____
What is the reason for this visit?_____ Is this your child's first dental visit?_____
Date of last dental visit_____Child's previous dentist_____Name of family dentist_____
Who may we thank for referring you to our office?_____
How do you expect your child to behave today?_____
Does your child have good physical coordination?____Has either parent or child been treated orthodontically?_____
Was your child bottle fed?____or breast fed?_____ until what age____
Oral habits: pacifier____,finger/thumb/lip sucking___,mouth breathing___,nail biting___,grinding___,clinch teeth___
Does your child brush regularly?_____ floss regularly?_____ Does adult help child brush/floss?_____
How may we help to make this visit a positive experience for your child_____
Describe any injuries to teeth, mouth, head_____
Does your child drink? Well water_____ City water_____Spring water_____ Bottled water_____
Does your child take fluoride supplements?_____ if so in what form_____

List all medicines your child is taking:_____
_____

Please check yes or no if your child has/had a history or difficulty with any of the following:

Medical / Dental condition	*Yes*	*No*	*Medical / Dental condition*	*Yes*	*No*	*Medical / Dental condition*	*yes*	*no*
Heart murmur	☐	☐	Cancer- list type	☐	☐	Bruising	☐	☐
Other heart conditions Describe:	☐	☐	Bone disorders	☐	☐	Speech Disorder	☐	☐
Allergy to medicine List:	☐	☐	Kidney problems	☐	☐	List other disorders:	☐	☐
Reaction to anesthesia	☐	☐	Liver problems	☐	☐	Pre-mature birth	☐	☐
Diabetes	☐	☐	AIDS/HIV	☐	☐	Nose bleeds	☐	☐
Asthma/breathing problems	☐	☐	Hepatitis	☐	☐	Fainting	☐	☐
High Blood Pressure	☐	☐	Rheumatic fever	☐	☐	Hearing problem	☐	☐
Latex allergies	☐	☐	Cerebral Palsy	☐	☐	Earaches	☐	☐
Allergy to food, dyes, other:	☐	☐	Bladder problems	☐	☐	Hearing	☐	☐
Brain, Head injuries	☐	☐	Seizures	☐	☐	Hypoglycemia	☐	☐
Mouth injuries	☐	☐	GERD (Reflux)	☐	☐	Gags easily	☐	☐

If you checked yes to any of the above to any of the medical or dental conditions please describe below in more detail. List any condition not mentioned above that applies to your child

_____
_____

* I acknowledge the above medical/dental history to be correct to the best of my knowledge.

Signature _____ Date_____