

PERSONAL HISTORY

Name: _____ Nickname: _____ Sex: Male or Female
Date of Birth: _____ Birth Place: _____ Weight: _____
Reason for last visit to medical doctor: _____ Date of Last Visit: _____
Who is the patients primary care doctor? _____
Who referred you to this dental office? _____

SOCIAL HISTORY

Does your child have problems with any of the following: Speech _____ Hearing _____ Vision _____ Sleep _____
Do you consider your child: Advanced in learning: _____ Progressing Normally: _____ Delayed in Learning: _____
Child's School: _____ Current Grade: _____
Child's first language: _____ Other language spoken: _____ Is your child adopted: Yes or No
Names and ages of brothers and sisters: _____

DENTAL HISTORY

Does your child receive fluoride in any form? Yes or No If yes, please explain: _____
Are you happy with the appearance of your child's teeth? Yes or No _____
If No, please explain: _____
Please describe how you think your child will behave today? Check all that apply:
Friendly: _____ Happy: _____ Anxious: _____ Timid: _____ Afraid: _____ Resistant: _____
Has your child ever worn retainers or other oral appliances? Yes or No

MEDICAL HISTORY

Were there any problems at birth? (If yes, please describe) _____
Birth Weight: _____ Is your child in good health now? Yes or No
Are your child's immunizations up to date? Yes or No Is your child taking medications now? Yes or No
If yes, List medications being taken: _____
Has your child had or does he or she have following:

Allergies	Yes or No	Asthma	Yes or No
If so, allergies to what _____		Operations or Hospitalizations	Yes or No
Reaction to any medicines	Yes or No	Facial injuries or toothaches	Yes or No
Latex Allergies	Yes or No	Abnormal bleeding or bruising	Yes or No
Heart trouble or heart murmur	Yes or No	Blood transfusions	Yes or No
Rheumatic heart disease or fever	Yes or No	Birth Defects	Yes or No
Blood disease or anemia	Yes or No	Kidney disease	Yes or No
Immunocompromised disease	Yes or No	Cleft lip or palate	Yes or No
Diabetes	Yes or No	Scarlet fever or other high fever	Yes or No
Ear, eye, nose or throat trouble	Yes or No	High or low blood pressure	Yes or No
Cancer, tumor, growth or cysts	Yes or No	Liver trouble	Yes or No
Any steroid therapy/chemotherapy	Yes or No	Convulsions or seizures	Yes or No
Nervous or mental disorder	Yes or No	Mumps	Yes or No
Frequent diarrhea or vomiting	Yes or No	Chicken Pox	Yes or No
Measels	Yes or No	Has your child ever had surgery?	Yes or No
Eating disorder	Yes or No	If so, what type? _____	

Is there any other information about your child the doctor should know about? Yes or No
If yes, please explain: _____
What is your relationship to this child? Mother _____ Father _____ Other: _____
Parent or legal Guardian: _____ Date: _____

Dentist: _____

Update Medical History _____
Update Medical History _____
Update Medical History _____