Child's Medical and Dental

CHILD'S DENTAL HISTORY

Reason for today's visit: Exam Emergency Consultation
Is Child in pain? No Yes How Long?_____
Please indicate any of the following problems with a check mark:
Discomfort, clicking, or popping in jaw Lost/Broken fillings Stained Teeth Red, swollen, or bleeding gums.

Teeth grinding Locking jaw Sensitive tooth, teeth, or gums Ringing in ears Bad breath

Blisters/Sores in or around mouth Broken/Chipped tooth Loose tooth

Other(s):_____
Does child require antibiotics prior to cleanings? Yes No Don't know
Is child considered to be a nervous patient? Yes No
Previous Dentist:_____ (_____)_____
Name Phone#
Last Dental exam:_____/_____/_____ Last Dental X-rays:_____/_____/_____
Times a day child brushes?_____ Times a week child flosses?_____
Does child use an electric toothbrush? Yes No Does child use a soft bristle toothbrush? Yes No
How would you rate the child's smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

CHILD'S MEDICAL HISTORY

Is child taking any of the following meds? Pain killers (including aspirin, etc.) Ritalin Stimulants Blood thinners Tranquilizers Insulin Muscle relaxers Other(s), please list:_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N *Heart Murmur*	**Y N** *Organ Problems*	**Y N** *Tonsillitis*
Y N *Rheumatic Fever*	**Y N** *Kidney Problems*	**Y N** *Asthma*
Y N *Artificial Heart Valves*	**Y N** *Liver Problems*	**Y N** *Hepatitis*
Y N *Congenital Heart Defect*	**Y N** *Respiratory Problems*	**Y N** *HIV+/AIDS/ARC*
Y N *Scarlet Fever*	**Y N** *Cleft Lip/Palate*	**Y N** *Difficulty Breathing*
Y N *Surgeries/Operations*	**Y N** *Artificial Bones/ Joints*	**Y N** *Diabetes/ Hypoglycemia*
Y N *Cancer/ Tumors*	**Y N** *Psychiatric Problems*	**Y N** *Birth Defects*
Y N *Chemotherapy*	**Y N** *Cerebral Palsy*	**Y N** *Fainting/ Seizures/ Epilepsy*
Y N *Jaw Problems TMJ/TMD*	**Y N** *High/ Low Blood Pressure*	**Y N** *Leukemia/Anemia*
Y N *Hearing Problems*	**Y N** *Tuberculosis TB*	**Y N** *Bleeding Problems*
Y N *Hyper Active/ADD*	**Y N** *Hemophilia*	**Y N** *Blood Transfusions*

Please list any other surgeries or medical conditions you have or ever had:_____
_____
Is Child allergic to: Latex Penicillin/ Amoxicillin Tetracycline Aspirin Codeine
Dental Anesthetics Foods:_____ Others:_____
Please rate the child's general health from 1 - 10:_____ Does child wear contact lenses? Yes No
Have you ever taken the drug Ritalin? No Yes/How Long?_____ Child's Blood type:_____
Does this child do any of the following? Thumb/Finger Sucking Tongue Thrusting/Sucking
Heavy Snoring Mouth Breathing Lip Sucking/Biting
Signature_____ Date_____/_____/_____
By signing above, I acknowledge that the above is true and correct to the best of my knowledge. (parent or guardian)