CHILD'S HISTORY

These questions are important so we have adequate information to take the best possible care of your child.

General Information

Child's Name:____ **Nickname:** ________________________

Please describe your child's personality/temperament: ____

Dental Information

Family dentist:____ Phone #:______________________

Date of your child's last dental checkup, cleaning, or x-rays: ____

Has your child had a history of: ☐ pacifier ☐ thumbsucking ☐ lip biting ☐ other ___________________________

Is your child taking fluoride pills or drops? ☐ Yes ☐ No

Did your child breast feed or use a bottle all night long? ☐ Yes ☐ No

Medical Information

Child's physician:____ Phone #:______________________

Date of last physical exam: ______________________________

Does your child have a history of:

Surgeries? ☐ Yes ☐ No List type: ____

Current medications? ☐ Yes ☐ No List type and dosages: ____

Allergic to any medications or latex? ☐ Yes ☐ No List: ____

Immunizations up to date? ☐ Yes ☐ No

Please circle if your child has a history of any of the following:

		Tuberculosis (TB)
Heart disease or murmur	Epilepsy, seizures, fainting	Gastrointestinal issues
Asthma	Developmental delay	Thyroid disease
Blood disorder	Behavioral/emotional problems	Hearing or vision problems
Blood transfusion	Arthritis	Speech delay
Diabetes	Motor or muscle disorder	Tobacco use
Liver disease	Cancer or tumors	Chemical dependency
Kidney disease	HIV/AIDS	Premature birth (Weeks? _________)

Females only: Is there any possibility of pregnancy? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Is your child adopted? ☐ Yes ☐ No **Does he/she know?** ☐ Yes ☐ No

Does your child have any other medical issues or special needs? ☐ Yes ☐ No Please list: ______________________

Signature of Parent/Guardian: ____ **Date:** ________________

Office Use Only	
Medical History Update	
Date: ________ Comments: __________________________	Date: ________ Comments: __________________________
Parent signature: ________________________________	Parent signature: ________________________________
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