PARADISE
DENTAL PROFESSIONALS

CHILDREN'S DENTAL/MEDICAL HISTORY

Patient's Name _____
Last First Initial Nickname Date of Birth
Parent/Guardian Name _____

DENTAL HISTORY – CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? .....YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays taken when your child previously visited the dentist? .....YES NO
4. Does your child eat between meals? .....YES NO
5. Does your child eat sweets, such as candy, soda, chewing gum? .....YES NO
6. When does your child brush his/her teeth?
   ____ Upon Rising ____ After eating any food ____ Right after meals ____ Before bed
7. How does your child receive fluoride?
   ____ Community water ____ Well Water ____ Fluoride drops/tablets ____Fluoride rinse or gel
8. Have any cavities been noted in the past? .....YES NO
9. Does your child suck his/her thumb or fingers? .....YES NO
10. Were any teeth (baby or permanent) removed by extraction? .....YES NO
    Was it suggested that the space be maintained? .....YES NO
    Was an appliance placed? .....YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc? .....YES NO
    If yes, please explain _____
12. Has your child had any problem with dental treatment in the past? .....YES NO
13. Has anyone in the family, including parents, had orthodontics? .....YES NO
14. Has your child ever received a local anesthetic? .....YES NO
15. Has your child ever had sealants? .....YES NO
16. Does your child think there is anything wrong with his/her teeth? .....YES NO

MEDICAL HISTORY

1. Does your child have a health problem? .....YES NO
   If yes, please explain _____
2. Is your child under the care of a physician? .....YES NO
   If yes, since when and why? _____
3. Name of physician _____ Phone # _____

4. Is your child receiving any medication? ……..YES NO
   If yes, what? _____

5. Is your child allergic to penicillin, antibiotics or other drugs? ……..YES NO
   If yes, what medications? _____
6. Is your child allergic or sensitive to any metals or latex? ……YES NO
   If yes, please explain _____
7. Does your child have any other allergies? ……YES NO
   If yes, please explain _____
8. Has your child had any serious illness? ……..YES NO
   When _____ What _____
9. Has your child ever had surgery? ……YES NO
   If yes, what kind of surgery? _____
10. Does your child have a heart murmur? ……..YES NO
11. Does your child experience severe or prolongated bleeding? ……..YES NO
12. Does your child have AIDS or has he/she tested HIV positive? ……..YES NO
13. Has your child tested positive for hepatitis? ……YES NO
14. Is your child subject to nervous disorders? ……..YES NO
    ____ Fainting ____Seizures ____ Dizziness ____Behavioral/Learning problems
15. Does your child have frequent headaches? ……YES NO
16. Has your child had a history of (mark the appropriate responses):
    ____ Diabetes
    ____ Heart problems
    ____ Asthma
    ____ Kidney Infection
    ____ Rheumatic Fever
    ____ Epilepsy
    ____ Cerebral palsy
    ____ Liver problems
    ____ Congenital birth defects
    ____ Cognitive disability
    ____ Eyesight problems

____ Cancer
____ Infections
____ Speech Impairments
____ Hearing loss

I CERETIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

COMMENTS/NOTES

_____

_____

_____