

• **Medical History** • For age 16 and under

Physician's name: _____ Date of last visit: _____

Is this the child's first visit? Yes No Is the child worried or apprehensive about this visit? Yes No

Please describe any current medical treatment, including drugs, impending operations, past hospitalizations or other information the doctor should be aware of: _____

Check any of the following that apply:

PREVIOUS DENTAL EXPERIENCE

- | | |
|---|--|
| <input type="checkbox"/> Experience was satisfactory | <input type="checkbox"/> Regular preventative visits made |
| <input type="checkbox"/> Local anesthetic given | <input type="checkbox"/> History of dental decay |
| <input type="checkbox"/> X-Rays taken | <input type="checkbox"/> Home oral care instructions given |
| <input type="checkbox"/> Special problems (Please describe) | |

SENSITIVITY IN THE MOUTH

- | | | |
|---------------------------------|----------------------------------|--|
| <input type="checkbox"/> Cold | <input type="checkbox"/> Heat | <input type="checkbox"/> Biting |
| <input type="checkbox"/> Sweets | <input type="checkbox"/> Chewing | <input type="checkbox"/> Previous Injury |

HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Thumb Sucking | <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Biting Hard Objects |
| <input type="checkbox"/> Tongue Thrusting | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Hard Swallowing |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Malignancies |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tonsils Out | <input type="checkbox"/> Adenoids Out |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Measles |

MEDICATIONS - Check any medications the child is currently taking:

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Over-the-Counter |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Natural Remedies |

List names of all medications the child is currently taking: _____

ALLERGIES - Check if the child is ALLERGIC to or has ever had any reaction to the following:

- | | |
|--|---|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Other Antibiotics | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Other Allergies (not listed) _____ |

Signature: _____

Date: _____