

DENTAL HISTORY

Name of **child's** Previous Dentist _____ Date of last Exam _____

Previous Dentist's Location _____ Date of last Cleaning _____

Reason for today's visit _____ Date of last dental X-rays _____

How often does your **child** floss? _____ How often does your **child** brush? _____

Please check () "yes" or "no" to indicate if your child has/had any of the following:

- | | | | |
|-----------------------------------|----------------------------------------------------------|--------------------------------|----------------------------------------------------------|
| Bad breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain or tiredness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding gums | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lip or cheek biting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blisters on lips or mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loose teeth or broken fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning sensation on tongue | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chew on one side of mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking or popping jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fingernail biting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food collection between the teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Foreign objects in mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Grinding teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity when biting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gums swollen or tender | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or growths in mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Medical History

Physician's Name _____ Date of last visit _____

Phone () _____ Pharmacy _____ Phone () _____

Please check () "yes" or "no" to indicate if your child has/had any of the following:

- | | | | | | |
|-----------------------|----------------------------------------------------------|-------------------------|----------------------------------------------------------|----------------------|----------------------------------------------------------|
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardiac Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | MVP | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swollen Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever/Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequently Tired | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Rplcmnt/Implant | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis/Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Troubles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS or HIV Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Trans. Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Troubles/Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | OTHER _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Allergic to any of the following?

- | | | | |
|------------------|----------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------|
| Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metals(i.e.gold) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Barbiturates | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Local Anesthesia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ibuprofen | <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No | Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| OTHER _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Please list all medications now taking: _____ | |

Ever taken any of these medications?

- | | |
|----------------|----------------------------------------------------------|
| Blood Thinners | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coumadin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Warfarin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Levoxyl | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Synthroid | <input type="checkbox"/> Yes <input type="checkbox"/> No |