

CHILD EXAMINATION - MEDICAL AND DENTAL HISTORY

(Please answer all questions)

Child's Name _____ Nickname _____ Date _____

Age _____ Date of birth _____ Home Telephone _____

Parent's Name _____ Work Telephone _____

School _____ Grade _____ Teacher _____

Name of child's Physician _____ Address _____

When was child's last medical examination? _____ Is child under the care of
a physician now? _____ For what reason? _____

Is child receiving any medication? _____ What? _____

Does child have any allergies? _____ To what? _____

Are there any diseases that run in the family? _____

Has child ever been hospitalized? _____ Has child ever had surgery? _____

Is there excessive bleeding when cut? _____ Are there any emotional problems? _____

Has child ever had a heart condition? _____ Rheumatic fever? _____ Asthma? _____

Tuberculosis? _____ Mononucleosis? _____ Bladder, kidney or liver problems? _____

Diabetes? _____ Hearing problems? _____ Chronic sinus? _____ Cerebral palsy? _____

Convulsions or epilepsy? _____ Chicken pox? _____ Mumps? _____ Measles? _____

Any other conditions that would be important for us to know? _____

Name of previous Dentist _____ City _____

Date of last visit to a dentist _____ For what? _____

Child's attitude to dentistry _____

Any unhappy dental experiences? _____ What? _____

Any mouth habits: Thumbsucking? _____ Mouth breathing? _____ Pacifier? _____

Nursing bottle habits? _____ Is fluoride taken in any form? _____

Thank you for your cooperation. If there is any other information which you feel would be of value to us in your child's dental treatment, please add it below.

Signature of Parent or Guardian _____ Date _____