Dakota Family Dentistry
Child Medical History Form

Patient's Name_____
Last First Initial Date of Birth

MEDICAL HISTORY- Circle the Appropriate Answer

1. Name of physician_____
2. Does your child have a health problem?----------YES NO
3. Is your child under care of a Physician?----------YES NO
   If yes, since when and why?_____
4. Is your child receiving any medication?----------YES NO
   If yes, what?_____
5. Has your child ever had surgery?----------YES NO
   If yes, what?_____
6. Has your child had any serious illness?----------YES NO
   If yes, when_____ what_____
7. Does your child have a heart murmur?----------YES NO
8. Is surgery contemplated?----------YES NO
9. Does your child experience severe or prolongated bleeding?----------YES NO
10. Does your child have AIDS or has he/she tested HIV positive?----------YES NO
11. Has your child tested positive for hepatitis?----------YES NO
12. Is your child subject to nervous disorders?----------YES NO
    _____Fainting _____Seizures _____Dizziness _____Behavioral/Learning problems
13. Does your child have frequent headaches?----------YES NO
14. Does your child have any allergies?----------YES NO
    _____Penicillin _____Latex/Metals _____Dental Anesthetics _____Aspirin _____Codeine
    Other_____
15. Has your child had history of: (Circle all appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

DENTAL HISTORY- Circle the Appropriate Answer

1. Is this your child's first visit to a dentist?----------YES NO
   If no, how long since the last visit to the dentist_____
2. Were any x-rays or radiographs taken when your child previously visited the dentist?----------YES NO
3. Does your child eat between meals?----------YES NO
4. Does your child eat sweets, such as candy, soda pop, chewing gum?----------YES NO
5. When does your child brush his/her teeth? (check all that apply)
   _____Upon arising _____After eating any food _____Right after meals _____Before going to bed
6. How does your child receive Fluoride? (check all that apply)
   _____Community water-level_____ppm _____Well water-level_____ppm
   _____Fluoride drops or tablets _____Fluoride rinse or gel
7. Has your child had any cavities in the past----------YES NO
8. Does your child suck his/her thumb or fingers?----------YES NO
9. Where any teeth (baby or permanent) removed by extraction?----------YES NO
   Was it suggested that the space by maintained?----------YES NO
   Was an appliance placed?----------YES NO
10. Have there been any injuries to teeth, like falls, blows, chips, etc?----------YES NO
    If yes, describe_____
11. Has your child had any problem with dental treatment in the past?----------YES NO
12. Has anyone in the family, including parents, had orthodontics?----------YES NO
13. Has your child ever received local anesthetic?----------YES NO
14. Has your child ever had occlusal sealants?----------YES NO
15. Do you think there is anything wrong with his/her teeth?----------YES NO
    If yes, explain_____
16. Do you have other conditions/problems not coved above?_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATENT'S / GUARDIAN'S SIGNATURE_____DATE_____