

FAMILY DENTAL HISTORY

Mom/Dad has history of frequent dental treatment? _____

Mom/Dad has weak teeth? _____

Mom/Dad has cavities as an adult? _____

Mom/Dad has congenitally missing teeth? _____

HEALTH HISTORY

Child's Physician _____ Phone _____

Date of last medical exam _____

CHECK ANY OF THE FOLLOWING THAT MAY PERTAIN TO YOUR CHILD:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cleft Lip / Palate | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Convulsions / Seizures | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nutritional Deficiency |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Orthopedic Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Hepatitis—Type _____ | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sickel Cell Anemia |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Excessive Bleeding Problem | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Syndrome |
| <input type="checkbox"/> Cerebral Palsey | <input type="checkbox"/> Fainting | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Other |

Child is in good health / None of the above

Explain any items checked above:

-
- Has your child **ever been hospitalized**? Yes/No _____
 - Is your child up to date with immunizations? Yes/No _____
 - Is your child **allergic to any medications**? Yes/No _____
 - Is your **child taking any current medications**? Yes/ No _____

 - Is your child **allergic to latex**? Yes/No _____
 - Have you ever been told that your **child needs premedication for a heart condition before dental treatment**? Yes/No If Yes, Explain:

Signature of person completing form

Relationship to patient

Date