Medical/Dental History – under 18

Patient Full Name _____ Nickname _____ Age _____

Parent/Legal Guardian Names (please list all) _____

Physician Name _____ Most recent visit _____ Purpose_____

What is your estimate of your child's general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Medical History

Please carefully review and indicate if your child has any history of the following conditions:

- ☐ ADHD/ADD
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Bladder/Kidney disease
- ☐ Bleeding disorders/ Excessive bleeding
- ☐ Chronic sinusitis
- ☐ Diabetes
- ☐ Ear aches/Infection
- ☐ Enlarged tonsils
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Genetic or inherited disorders
- ☐ Growth Problems
- ☐ Headaches
- ☐ Hearing loss
- ☐ HIV/AIDS
- ☐ Latex allergy
- ☐ Liver disease/Hepatitis
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Speech issues
- ☐ Hives/Skin Rashes
- ☐ Thyroid disease
- ☐ Tobacco/drug use
- ☐ Tuberculosis
- ☐ STDs
- ☐ Viral infections/cold sores
- ☐ Vision concerns

List all mediations your child is taking:

Please indicate any allergies:

- ☐ Drugs/Medications:
- ☐ Food:
- ☐ Metals:
- ☐ Other:

Has your child ever had surgery or anesthesia? If yes, did your child experience any complications?

- ☐ No
- ☐ Yes _____

Are your child's immunizations up to date? If no, please explain.

- ☐ Yes
- ☐ No _____

Dental History

Is this your child's first dental visit? If no, list the date of last visit.

- ☐ Yes
- ☐ No _____

Has your child ever had and unfavorable experience or reaction associated with a dental visit? If yes, please explain.

- ☐ No
- ☐ Yes _____

Has your child had any injuries to their mouth, teeth or head? If yes, please explain.

- ☐ No
- ☐ Yes _____

What type of water does your child drink the most?

- ☐ City (tap) water
- ☐ Bottled water
- ☐ Filtered water

Does your child take fluoride supplements?

- ☐ Yes
- ☐ No

Does your child use a fluoride toothpaste?

- ☐ Yes
- ☐ No

How many times are your child's teeth brushed per day? _____ Flossed? _____

Is brushing and flossing supervised and/or assisted?

- ☐ Yes
- ☐ No

Has your child complained of any recent dental pain? If yes, please explain.

- ☐ No
- ☐ Yes _____

Please answer the following regarding past and current feeding and habits:

Thumb/finger sucking habit/Pacifier use:

- ☐ Past
- ☐ Current
- ☐ Never

Age when stopped: _____

Teeth grinding/clenching:

- ☐ Past
- ☐ Current
- ☐ Never

Age when stopped: _____

Fingernail biting:

- ☐ Past
- ☐ Current
- ☐ Never

Age when stopped: _____

Snoring/sleep issues:

- ☐ Past
- ☐ Current
- ☐ Never

Please describe: _____

Any other dental concerns/comments?

We like to use friendly, non-scary dental words in our office – and we would love to share these with you and your child. Please help support a healthy dental experience for your child by avoiding telling any of your own traumatic dental stories or using words like "shot", "pain", or other similar language.

As this child's parent or legal guardian, I confirm that this information is correct to the best of my knowledge. I understand that misrepresenting or withholding medical or dental information can be harmful to my child during treatment.

Please advise us in the future of any changes in your child's medical history or medications.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Relationship to child: _____

Doctor's Signature: _____ Date: _____