



## CHILD MEDICAL & DENTAL HISTORY

Child Name (Print) \_\_\_\_\_ DOB: \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

### Medical History

1. Does your child have a health problem? \_\_\_\_\_
2. Is your child under care of a physician? ☐ yes ☐ no  
Physician's Name & Office Number \_\_\_\_\_
3. Is your child allergic to penicillin, antibiotics, or other drugs? \_\_\_\_\_
4. Is your child allergic to latex? \_\_\_\_\_
5. Does your child have any other allergies? \_\_\_\_\_
6. Has your child any serious illness (what and when)? \_\_\_\_\_
7. Has your child ever had surgery? \_\_\_\_\_
8. Does your child have a heart murmur? \_\_\_\_\_
9. Does your child have a bleeding disorder? \_\_\_\_\_
10. Has your child been tested positive for hepatitis? \_\_\_\_\_
11. Does your child have problems with fainting, seizures, dizziness? \_\_\_\_\_
12. Does your child have frequent headaches? \_\_\_\_\_
13. Is your child currently taking any medications? If so please list:  
\_\_\_\_\_
14. Other medical conditions we should be aware of? \_\_\_\_\_  
\_\_\_\_\_

### Dental History

1. Is this your child's first visit to the dentist? \_\_\_\_\_
2. How often does your child brush their teeth? \_\_\_\_\_
3. Has your child ever had cavities? \_\_\_\_\_
4. Has your child ever had braces or consultation with an orthodontist? \_\_\_\_\_
5. Has your child ever had any teeth extracted? \_\_\_\_\_
6. Has your child ever had trauma to their teeth? \_\_\_\_\_
7. Has your child ever had problems with dental treatment in the past? If yes, explain:  
\_\_\_\_\_
8. Has your child been complaining of teeth problems? If yes, please explain:  
\_\_\_\_\_
9. Is there anything else you would like to discuss with us about your child?  
\_\_\_\_\_

I certify that the above information is complete and accurate.

Parent/Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date: \_\_\_\_\_

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