PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial Date of Birth

PARENT'S NAME _____
Last First Initial

CIRCLE THE APPROPRIATE ANSWER

COMMENTS

DENTAL HISTORY

1. Is this the child's first visit to a dentist? ..... YES NO
2. If not, how long since the last visit to the dentist? _____
3. Does the child eat between meals? ..... YES NO
4. Does the child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
5. Does the child eat well balanced meals? ..... YES NO
6. Does child brush teeth upon arising ..... YES NO
   when going to bed ..... YES NO
   right after eating meals ..... YES NO
   after eating any food? ..... YES NO
7. Do you live in an area without fluoridated water? ..... YES NO
8. Have teeth been treated with fluorides? ..... YES NO
9. Have any cavities been noted in the past? ..... YES NO
10. Were any teeth (baby or permanent) removed by extraction? ..... YES NO
    Was it suggested that the space be maintained? ..... YES NO
    Was appliance placed? ..... YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... YES NO
    If so, describe _____
12. Has child had any unfavorable dental experiences? ..... YES NO
13. How many children in your family? _____
14. Has anyone in the family, including parents, had orthodontics? ..... YES NO
15. Has child ever received a local anesthetic? ..... YES NO
16. Has child ever had occlusal sealants? ..... YES NO

MEDICAL HISTORY

1. Is child in good health? ..... YES NO
2. Is child under care of physician? ..... YES NO
   If yes, since when and why _____
3. Name of physician _____
4. Has the child had any serious illness? ..... YES NO
   When _____ Why _____
5. Has child had surgery? ..... YES NO
6. Is surgery contemplated? ..... YES NO
7. Is child subject to profuse bleeding? ..... YES NO
8. Is child subject to nervous disorders ..... YES NO
   fainting ..... YES NO
   dizziness? ..... YES NO
9. Does the child have allergies? ..... YES NO
10. Is the child allergic to penicillin, antibiotics or other drugs? ..... YES NO
11. Is child receiving any medication? ..... YES NO
    What? _____
12. Has child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. 131CDM

CHILD DENTAL MEDICAL HISTORY