Medical and Dental History

Patient's Name_____ Birthdate_____ Age_____ □ Male □ Female

MEDICAL HISTORY

Physician_____

Yes No
( ) ( ) Is patient in good health?
( ) ( ) Is patient under a physicians care? For what?_____
( ) ( ) Does patient have any history of major illness? What?_____
( ) ( ) Has patient ever been hospitalized? For what?_____
( ) ( ) Is the patient receiving any medication/drugs presently?_____
( ) ( ) Does patient have any allergies or drug sensitivity? Kindly List_____
( ) ( ) Does patient have a tendency to colds( ), sore throat( ), ear infections( ), sinus congestion( ), breathing problems( )
( ) ( ) Have tonsils and/or adenoids been removed? What age?_____

Check any of the following conditions for which the patient has been treated:

( ) ADHD/ADD
( ) Asthma
( ) Autism
( ) Blood Disorders
( ) Cerebral Palsy
( ) Developmental Delays
( ) Diabetes
( ) Epilepsy/Seizures
( ) Emotional Problems
( ) Endocrine Problems
( ) Fainting/Dizziness
( ) Heart Problems
( ) Liver/Kidney Disease
( ) Nutritional Problems
( ) Prolonged Bleeding
( ) Speech, Hearing Problem

Any other significant medical, psychological, or disability concerns? ___ Please describe. _____
_____

DENTAL HISTORY

Previous Dentist_____

Yes No
( ) ( ) Has there been any injury to your child's mouth, face or teeth in the last 3 years? _____
( ) ( ) Do you have any concerns about the color, size or shape of your child's teeth? _____
( ) ( ) Do you have any questions/concerns about the position (crowding, spacing, overbite) of your child's teeth
_____
( ) ( ) Has your child ever complained of tenderness/pain in the jaw joint (TMJ) area or had their jaw 'lock' open or shut?
( ) ( ) Does your child play sports? _____ If so, do they wear a mouth guard?_____
( ) ( ) Does your child drink sports drinks or energy drinks on a regular basis?
( ) ( ) Is your child using a mouth rinse?
If so, what kind and how often? _____
( ) ( ) Does your child floss? If so, how many times a week? _____

Please list any other concerns:
_____
_____

I acknowledge that this information is correct and hereby authorize a comprehensive examination including necessary radiographs and other indicated diagnostic procedures needed to accomplish these services. I authorize the use of any radiographs, photographs, and records for the purpose of teaching other health care professionals.

_____ _____ _____ _____
Signature of Legal Consent *Date* *Dentist Signature* *Date*

Internal use only

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