

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:

- | | | |
|---|---|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Epilepsy/Seizures | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Nutritional Problems |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Speech, Hearing Problem |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Problems | |
| <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Liver/Kidney Disease | |
| <input type="checkbox"/> Diabetes | | |

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

DENTAL HISTORY

Previous Dentist _____

Yes No

- Has there been any injury to the mouth, face or teeth in the last 3 years?
If yes, Please explain _____
- Do you have any concerns about the color, size or shape of your child's teeth?

- Do you have any questions about the position of your child's teeth or future braces?
- Do you ever hear your child grind their teeth at night?
- Has your child ever complained of tenderness/pain in the jaw joint (TMJ) area?
- Do you live in any of the following fluoridated water communities? Beaverton, McMinnville, Troutdale or Keizer?
- Is your child taking a fluoride supplement routinely?
- Is your child using a mouth rinse? If so, what kind? _____
- Does your child have any specific concerns or sensitivities about going to the Dentist? _____
- Does your child ever report any discomfort or bleeding during brushing?

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

Date

Internal use only

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