Westbank Dental

CHILD MEDICAL/DENTAL HISTORY FORM

Patient Name_____ **DOB** _____ **Date** _____

Guardian's Name _____ **Relationship to Patient:** _____

Physician's Name _____ Phone No._____

Date of most recent exam _____ Purpose of visit _____

	YES	NO
Does your child have any health problems?	O	O
Does your child have any allergies to any medications (ie penicillin) or latex?	O	O
Does your child have any other allergies?	O	O
If so, please list:	O	O
Has your child ever had a serious illness or been hospitalized?	O	O
Has your child ever had surgery or are any surgeries planned?	O	O
Is your child taking any prescribed or over-the-counter medications?	O	O
If so, please list:		

Does your child have a history of any of the following? (Please circle all that apply.)

Asthma	Hepatitis	Intellectual Disability
Heart Problems	AIDS/HIV	Eye Problems
Liver Problems	Fainting/Dizziness	Speech Impairments
Kidney Problems/Infections	Seizures/Epilepsy	Hearing Loss Lung
Problems	Behavioral/Learning Disorders	Infections
Diabetes	Rheumatic Fever	Tuberculosis
Heart Murmur	Cerebral Palsy	Nervous Disorders
Prolonged/Severe Bleeding	Congenital Birth Defects	Growth Problems

	YES	NO
Is this your child's first dental visit? If not, when was the last visit?	O	O
Has your child ever had an unfavorable dental experience?	O	O
Has your child ever received local anesthetic?	O	O
Does your child eat between meals?	O	O
Has your child had protective sealants placed on his/her teeth?	O	O

Does your child: brush upon rising? _____ brush after any meal? _____

right after meals? _____ before going to bed? _____

Has your child ever suffered any injuries to the head, mouth, or neck?	O	O
Has your child ever had any teeth extracted (baby or adult)?	O	O
Has your child had cavities diagnosed in the past?	O	O
Does your child use toothpaste containing fluoride?	O	O

What type of water does your child drink? O City O Well O Bottled O Filtered

Please list any concerns that you have about your child's dental health. _____

I certify that the above information is complete and correct.

Patient's (Guardian's) signature:_____ Date:_____

Doctor's signature:_____ Date:_____