Child Medical & Dental History Form

Patient's Name: _____ **DOB:** _____ **Age:** _____

A Note to Our Parents:
Although dentists primarily treat areas in and around the mouth, it is a part of the entire body. Health problems that your child may have or medications that your child may be taking could have an important interrelationship with the care that he/she will be receiving. Thank you for answering the questions. Your answers are for our records and will be considered confidential.

Have you (parent or guardian) or the patient had any of the following diseases or problems? □ Yes □ No
1. Active Tuberculosis 2. Persistent cough greater than a 3 week duration. 3. Cough that produces blood.
If you answer yes to any of these items above, please stop and return this form to the receptionist.

Has your child had any history of, difficulty with , or diagnosis of any of the following: *[please check appropriate box(es)]*

[ ] Heart Condition	[ ] Handicap/Disabilities	[ ] Lung Disorder	[ ] Liver Problems	[ ] Epilepsy/Seizures
[ ] Asthma	[ ] Tuberculosis	[ ] Nose/Throat Disorder	[ ] Kidney Problems	[ ] ADD/ADHD
[ ] Latex Allergy	[ ] Skin Disorders	[ ] Cancer/Tumors	[ ] Ear Problems/Tubes	[ ] Mental/Emotional
[ ] Blood Disease	[ ] Rheumatic Fever	[ ] HIV+/AIDS	[ ] Speech Problems	Disorders
[ ] Diabetes	[ ] Hepatitis	[ ] Stomach Problems	[ ] Vision Problems	[ ] Other

Please explain any medical condition that your child has: _____
_____

Child's Physician: _____ Phone: _____

Medical History:

		Yes	No
1.	Is the child taking any medication at this time? Please list: _____	1. [ ]	[ ]
2.	Is the child allergic to any medications, i.e. penicillin, or other drugs? Please list: _____	2. [ ]	[ ]
3.	Is the child allergic to anything else, such as certain foods? Please explain: _____	3. [ ]	[ ]
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever been seriously ill? When: _____ Please explain: _____	5. [ ]	[ ]
6.	Has the child ever been hospitalized? Please explain: _____	6. [ ]	[ ]
7.	Does the child have a history of any other illnesses? Please explain: _____	7. [ ]	[ ]
8.	Has the child ever received a general anesthetic?	8. [ ]	[ ]
9.	Does the child have any inherited problems?	9. [ ]	[ ]
10.	Has the child ever had a blood transfusion?	10. [ ]	[ ]
11.	Does the child experience excessive bleeding when cut?	11. [ ]	[ ]
12.	Is the child currently being treated for any illness?	12. [ ]	[ ]

Dental History:

		Yes	No
1.	Is this the child's first visit to the dentist? If not, what was the date of the last dentist visit? Date: _____	1. [ ]	[ ]
2.	Has the child had any problem(s) with dental treatment in the past?	2. [ ]	[ ]
3.	Has the child ever had dental radiographs (x-rays) exposed?	3. [ ]	[ ]
4.	Has the child ever suffered any injuries to the mouth, head, or teeth?	4. [ ]	[ ]
5.	Has the child had any orthodontic treatment?	5. [ ]	[ ]
6.	What type of water does your child drink? [ ] City water [ ] Well water [ ] Bottled water		
7.	Does the child take fluoride supplements? Pills or Drops? _____ Dosage: _____mg.	7. [ ]	[ ]
8.	Is fluoride toothpaste used?	8. [ ]	[ ]
9.	How many times are the child's teeth brushed per day? _____ When are they brushed? _____		
10.	Does the child suck his/her thumb, fingers, or pacifier?	10. [ ]	[ ]
11.	Is the child bottle feeding? If no, at what age was it discontinued? _____	11. [ ]	[ ]

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the Dr. Kuwabara, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature: _____ Date: _____

ALLERGIES

MED. ALERT

MEDICAL/DENTAL HISTORY