

# CHILD HEALTH HISTORY

**PARENT/GUARDIAN:** The purpose of the following is to determine if your child has a medical condition that may require special care. All information is confidential and kept in your child's dental record. Please complete this form and remain in the dental office while your child is receiving treatment.

Name \_\_\_\_\_

Date of child's last medical examination: \_\_\_\_/\_\_\_\_/\_\_\_\_ Current Height: \_\_\_\_\_ feet \_\_\_\_\_ inches

Reason: \_\_\_\_\_ Current Weight: \_\_\_\_\_ pounds

Name of child's physician: \_\_\_\_\_

## Medical History

**Yes No**

☐ ☐ Is the child taking any medicines now, including birth control pills, aspirin, tylenol? Please list: \_\_\_\_\_

☐ ☐ Is the child being treated by a physician now?

☐ ☐ Has the child ever taken the prescription diet drug: ☐ Fen-phen ☐ Redux ☐ Pondimin?

☐ ☐ Has the child ever had any injuries to the face or jaw? Please list: \_\_\_\_\_

☐ ☐ Does the child bleed excessively with cuts or dental extractions?

☐ ☐ If female, is the child pregnant? Due date: \_\_\_\_\_

☐ ☐ Is the child allergic to any of the following? (if yes, check all that apply)

☐ Latex rubber ☐ Sulfa ☐ Penicillin ☐ Iodine ☐ Aspirin ☐ Codeine ☐ Dental Anesthetics

☐ ☐ Is the child allergic to other medicines not listed? Please list: \_\_\_\_\_

☐ ☐ Is the child allergic to any foods? Please list: \_\_\_\_\_

**Please indicate if this child has been diagnosed or treated for any of the following:**

(circle) Year	(circle) Year	(circle) Year
Y N _____ Heart Disease	Y N _____ Kidney Disease	Y N _____ Alcohol Dependency
Y N _____ Heart Murmur	Y N _____ A-V Shunt (Kidney dialysis)	Y N _____ Drug Dependency
Y N _____ Rheumatic Fever	Y N _____ Asthma	Y N _____ Convulsions/Seizures
Y N _____ Artificial Bones/Joints	Y N _____ Lung Problems	Y N _____ Stroke
Y N _____ Implants	Y N _____ Tuberculosis (TB)	Y N _____ Epilepsy
Y N _____ HIV+/AIDS	Y N _____ Bloody/Productive Cough	Y N _____ Oral Herpes
Y N _____ Cancer	Y N _____ Unexplained Weight Loss	Y N _____ Syphilis, G.C.
Y N _____ Radiation Therapy	Y N _____ Unexplained Appetite Loss	Y N _____ Mental Disorder
Y N _____ Lupus	Y N _____ Unexplained Fevers	Y N _____ Nervous Disorder
Y N _____ Hodgkins	Y N _____ Night Sweats	Y N _____ Stomach Ulcers
Y N _____ Diabetes	Y N _____ Arthritis	Y N _____ Hemophilia
Y N _____ Pacemaker	Y N _____ Thyroid Disorder	Y N _____ Other Bleeding Disorder
Y N _____ High/Low Blood Pressure	Y N _____ Hepatitis Type _____	Y N _____ Blood Transfusion

**Yes No**

☐ ☐ Was child born of a normal 9 month pregnancy? If premature, how many months? \_\_\_\_\_ Birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

☐ ☐ Has child ever been hospitalized? Date and reason: \_\_\_\_\_

☐ ☐ Is child physically or mentally handicapped in any way? If yes, how: \_\_\_\_\_

☐ ☐ Does child need an update on immunizations? Has child ever received general anesthesia or sedation? ☐ Yes ☐ No

☐ ☐ Is child in the grade appropriate for his/her age?

**I have answered these questions for the patient (child) to the best of my knowledge and ability.**

Signature of parent or legal guardian \_\_\_\_\_

Date \_\_\_\_\_

# CHILD HEALTH HISTORY

Why have you come to the dentist today? ☐ Routine exam ☐ Special problem \_\_\_\_\_

Name of child's previous dentist: \_\_\_\_\_ City / State: \_\_\_\_\_

When did child see dentist last? \_\_\_\_\_ Did child have X-rays taken at that time? ☐ Yes ☐ No

What was the reason for child seeking dental treatment at that time? ☐ Routine exam ☐ Teeth cleaning ☐ Special problem

If special problem, please explain: \_\_\_\_\_

At what age did child stop bottle/breast feeding? \_\_\_\_\_

## Yes No

☐ ☐ Has child previously complained about dental problems? Please explain: \_\_\_\_\_

☐ ☐ Is child extremely nervous or anxious while receiving dental treatment? Please explain: \_\_\_\_\_

☐ ☐ Are you (parent/guardian) nervous or anxious while you are receiving dental treatment?

☐ ☐ Has child had any injuries to the mouth, teeth or head? Please explain: \_\_\_\_\_

☐ ☐ Has child ever had dental X-rays taken? If yes, when? \_\_\_\_\_

☐ ☐ Does child have any mouth habits (thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.)? \_\_\_\_\_

☐ ☐ Does child have unusual speech habits? Please explain: \_\_\_\_\_

☐ ☐ Has child worn orthodontic appliances now or in the past? Please explain: \_\_\_\_\_

☐ ☐ Is child assisted with tooth brushing? How often are the child's teeth brushed? \_\_\_\_\_ times daily \_\_\_\_\_ times weekly  
How often are child's teeth flossed? \_\_\_\_\_ times daily \_\_\_\_\_ times weekly

☐ ☐ Does child use toothpaste? What type? \_\_\_\_\_

☐ ☐ Is child's drinking water fluoridated?

☐ ☐ Is child taking fluoride in any other form? Please explain: \_\_\_\_\_

☐ ☐ Has any member of the family ever had an unusual dental history, such as missing or extra teeth? Please explain: \_\_\_\_\_

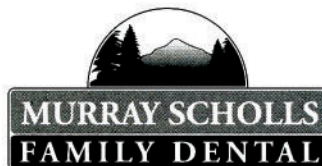
☐ ☐ Does child snack or frequently consume sugar such as gum, soda pop, Life Savers or fruit juices? Please explain: \_\_\_\_\_

## For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



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