CHILD HEALTH HISTORY

PARENT/GUARDIAN: The purpose of th 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 offic 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 herin. Initials:____ Date:_____

Doctor's Comments:_____

MURRAY SCHOLLS FAMILY DENTAL

Scott R. Walker, DMD

14845 SW MURRAY SCHOLLS DRIVE, SUITE 113 • BEAVERTON, OR 97007 • 503-590-7574 FAX 503-590-8664

WWW.MURRAYSCHOLLSFAMILYDENTAL.COM