Geoffrey R. Gamache, DDS, Rosanne Sundstrom, DDS, Robert P. Buckley, DDS, Christina T. O'Brien, DDS

Medical History / Child

Last Name: ______________________ First Name: ______________________ Birthdate: ____________________

Name of Medical Doctor: ______________________________________ Phone ____________________

Parent/Guardian Name ____ Phone ______________

Does your child have, or have they ever had any of the following:

Y	N	Condition	Y	N	Condition	Y	N	Condition	Y	N	Condition
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Heart Valve Replacement	☐	☐	Liver Problems
☐	☐	Bleeding Disorder	☐	☐	Eyesight Problems	☐	☐	Hepatitis A, B, C	☐	☐	Mental Disorders
☐	☐	Cancer-Chemotherapy	☐	☐	Fainting or Dizziness	☐	☐	HIV - AIDS	☐	☐	Nervousness
☐	☐	Cerebral Palsy	☐	☐	Frequent Headaches	☐	☐	Infections	☐	☐	Rheumatic Fever
☐	☐	Congenital Birth Defects	☐	☐	Hearing Loss	☐	☐	Kidney Infections	☐	☐	Seizures
☐	☐	Diabetes	☐	☐	Heart Problems	☐	☐	Learning Disability	☐	☐	Speech Impairments

Does your child have any health problem currently that is not listed above? Please explain:

____

Has your child ever had a serious illness? If yes, please explain:

____

Has your child ever had surgery? If yes, please explain:

____

Is your child currently taking any medications? Please list below:

______________________ ______________________ ______________________

Is your child allergic to antibiotics, other drugs, metal or latex? Please list below:

Y	N	Allergy	Y	N	Allergy	Y	N	Allergy	Y	N	Allergy
☐	☐	Local Anesthetic	☐	☐	Codeine	☐	☐	Iodine	☐	☐	Penicillin
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Latex	☐	☐	Sulfa
☐	☐	Clindamycin	☐	☐	Ibuprofen	☐	☐	Metals	☐	☐	Tetracycline

Dental History

Y	N	Question
☐	☐	Is this your child's first visit to the dentist? If not, when was their last visit?
☐	☐	Were any x-rays or radiographs taken when your child previously visited the dentist?
☐	☐	Does your child eat between meals?
☐	☐	Does your child eat sweets such as candy, soda and chewing gum?
☐	☐	Have any cavities been noted in the past?
☐	☐	Were any teeth (baby or permanent) removed by extraction?
☐	☐	If teeth were removed, was it suggested that the space be maintained?
☐	☐	Was an appliance placed to maintain the space?
☐	☐	Has your child suffered any injuries to teeth such as falls, blows, chips etc?
☐	☐	Has anyone in your family had orthodontic treatment?
☐	☐	Has your child ever received a local anesthetic?
☐	☐	Has your child ever had occlusal sealants?
☐	☐	Does you child think there is anything wrong with his/her teeth?

When does your child brush his/her teeth?

____

How does your child receive fluoride?

____

Name of former dentist ______________________________ City/State ____________________

Date of last cleaning and exam ____

____

Signature

Date: