Eastview Dental Professionals

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:

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

- ☐ Local Anesthetic
- ☐ Aspirin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline

Dental History

- ☐ 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: