CHILD'S HEALTH HISTORY

Date of Last Dental Visit _____

What did you see the Dentist for? _____

What Dentist do you see? _____

	Yes	No
Any previous unhappy medical or dental visits?	Yes	No
Has your child complained of any dental problems?	Yes	No
Any injuries of the mouth, teeth, or head?	Yes	No
Any mouth habits: Nail biting, thumb-sucking etc….?	Yes	No
Has your child lost any teeth since his/her last dental visit?	Yes	No
Does your child brush his/her teeth daily?	Yes	No
Do you help assist your child with brushing his/her teeth?	Yes	No
If yes, how often do you help your child?	Yes	No
Does he/she use Dental Floss?	Yes	No
How does your child receive Fluoride?	Yes	No

Water supply _____ Toothpaste _____ Dentist _____ Vitamins _____ Tablets _____ None _____

How is your child's attitude towards dentistry? _____

MEDICAL HISTORY

Child's Primary Physician _____

Physician's Address (street, City, State, Zip) Phone Number

_____

Date of last Examinations _____

Result's of last examination _____

	YES	NO
Is your child in good health?	Yes	No
Is your child presently under care by a physician?	Yes	No
Is your child receiving any medications or drugs?	Yes	No

If yes, what? _____

What is your child's weight? _____ lbs. Height _____

Has your child ever been hospitalized?	Yes	No

If yes, when? _____

Eating Habits presently (briefly explain) _____

_____

Are there any psychological or emotional problems?	Yes	No

if yes, please explain _____

_____

Have they has any of the following problems?

1.	Rheumatic Fever/ Heart Disease	Yes	No
2.	Congenial Heart Disease or Heart Murmur	Yes	No
3.	Allergies	Yes	No

If yes, what? _____

Food, Dust, etc. _____

Drugs i.e. Penicillin etc. _____