Dr. Beverly Morris, D.D.S. *CHILD MEDICAL / DENTAL HISTORY*

Patients Name _____

Last First Initial Date of Birth

Parent's Guardian's Name _____

COMMENTS

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

DENTAL HISTORY

1. Is this your child's first visit to a dentist? …….. YES NO
2. If not, how long since last visit? …… YES NO
3. Were any x-rays taken at by previous dentist? …….. YES NO
4. Does your child eat sweets, such as candy, pop, chewing gum? …… YES NO
5. When does your child brush his/her teeth?
   ☐ Upon Rising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
6. Has your child received fluoride drops or tablets? ……..…. YES NO
7. Has your child been raised on community, well or bottled water? ….. (circle one)
8. Were any teeth (baby or permanent) removed by extraction? …….. YES NO
   Was it suggested that the space be maintained? …… YES NO
   Was an appliance placed? …… YES NO
9. Have any cavities been noted in the past? …… YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc? … YES NO
    If so describe _____
11. Has your child had any problems with dental treatment in the past? …… YES NO
12. Has anyone in the family, including parents, had orthodontics? …… YES NO
13. Has your child ever received local anesthetic? …….. YES NO
14. Has your child ever had occlusal sealants? …… YES NO
15. Does your <u>child</u> think there is anything wrong with his/her teeth? …… YES NO

MEDICAL HISTORY

1. Does your child have any health problems? …… YES NO
2. Is your child under care of physician? …… YES NO
   If yes, since when and why? _____
3. Name of Physician _____ Phone: _____
4. Is your child receiving any medication? …… YES NO
   Name of medication _____
5. Is your child allergic to penicillin, antibiotics or other drugs? …… YES NO
6. Is your child allergic or sensitive to any metals or latex? …… YES NO
7. Does your child have any other allergies? …… YES NO
8. Has your child had any serious illness? …… YES NO
   What? _____ When? _____
9. Has your child ever had surgery? …… . YES NO
10. Does your child have a heart murmur? …… YES NO
11. Does your child experience severe or prolongated bleeding? …… YES NO
12. Does your child have AIDS or has he/she tested HIV positive? …… YES NO
13. Has your child tested positive for hepatitis? …… YES NO
14. Is your child subject to nervous disorders? …….. YES NO
    ☐ Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning problems?
15. Does your child have frequent headaches? …….. YES NO
16. Has your child had history of: (circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

DENTIST SIGNATURE _____ DATE _____

Medical Alert