# Medical and Dental History

| Child's Name | Nickname | Birthdate | Today's Date |
|---|---|---|---|
| | | | |

**Purpose of this visit** _____

*Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.*

| | Y | N |
|---|---|---|
| 1. Name of previous dentist: _____ | | |
| 2. Phone # of previous dentist: _____ | | |
| 3. Any unhappy dental experiences? _____ | □ | □ |
| 4. Any injuries to mouth, teeth, head? _____ | □ | □ |
| 5. Any mouth habits-thumb sucking, nail biting, mouth breathing, nursing, bottle, pacifier, etc?_____ | □ | □ |

| | Y | N |
|---|---|---|
| 6. Attitude towards dentistry: □Normal □Shy □Apprehensive □Frightened | | |
| 7. Brush teeth daily? | □ | □ |
| 8. Do you assist with toothbrushing? | □ | □ |
| 9. Take any fluoride supplements? | □ | □ |
| 10. Orthodontic appliances or braces worn now or ever? | □ | □ |
| 11. Any unusual speech habits? _____ | □ | □ |

**Child's Physician**_____ **City** _____**Phone**_____

| | Y | N |
|---|---|---|
| 1. Under care of physician now? | □ | □ |
| 2. Receiving any medication or drugs?_____ | □ | □ |
| 3. Ever been hospitalized? _____ | □ | □ |
| 4. Ever had surgery? _____ | □ | □ |

| | Y | N |
|---|---|---|
| 5. Any physical coordination issues? _____ | □ | □ |
| 6. Are there any emotional issues? _____ | □ | □ |
| 7. Vaccinations up to date? | □ | □ |
| 8. Ever had a blood transfusion? | □ | □ |

**Any history of, or difficulty with any of the following?**

| | | | | | | |
|---|---|---|---|---|---|---|
| □ Asthma | □ Bleeding Disorders | □ Chronic Sinus | □ Hepatitis | □ Hearing | □ Kidney | □ Rheumatic Fever |
| □ Anemia | □ Cerebral Palsy | □ Convulsions | □ HIV/AIDS | □ Hemophilia | □ Liver | □ Disabilities/Handicap |
| □ Cancer | □ Heart | □ Diabetes | □ Epilepsy | □ Fainting | □ Tuberculosis | □ Other |

**Any allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc)?** _____

_____

**Allergies to any other substance (latex,peanuts,etc)?**_____

**Please describe any current medical treatment including drugs, pending surgery, recent injuries, medical conditions, or any other information I should be aware of that we have not discussed…** _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand the provided incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I will not hold Dr. Leland Shenfield responsible for any error or omissions that I may have made in completion of this form.

_____/_____ _____

Signature of Parent or Legal Guardian Print Name Date