

DENTAL HISTORY

Is this your child's first dental visit? Yes No
 Previous Dentist's Name? _____
 Date of last visit: _____
 Does your child feel nervous about having dental treatment? Yes No
 Has your child ever had a bad dental experience? Yes No
 Has your child been seen by an orthodontist? Yes No

Have there been any injuries to your child's teeth or jaws? Falls? Blows? Chips? etc? Yes No
 Has your child ever been premedicated for dental work? Yes No
 Does your child receive fluoride in vitamins, tablets, or water? Yes No

HEALTH HISTORY

Is your child having any pain or discomfort at this time? Yes No
 Has your child been hospitalized during the past 2 years? Yes No
 Has your child been under the care of a medical doctor during the past 2 years? Yes No
 Physician Name _____
 Address _____ Phone: _____

Is your child currently taking any medications? Yes No
 If yes, please list: _____
 Has your child taken any medicine / drugs during the past 2 years? Yes No
 If yes, please list: _____
 Please list any serious medical condition(s) that your child has or has had:

Please check "Yes or No" to the following conditions:

- | | | |
|--|--|---|
| <p>Y N
 <input type="checkbox"/> High / Low Blood Pressure
 <input type="checkbox"/> Congenital Heart Defect
 <input type="checkbox"/> Heart Murmur / Rheumatic Fever
 <input type="checkbox"/> Heart Surgery
 <input type="checkbox"/> Diabetes
 <input type="checkbox"/> Blood Transfusion / Anemia
 <input type="checkbox"/> Sickle Cell Disease
 <input type="checkbox"/> Bruise Easily
 <input type="checkbox"/> Hemophilia
 <input type="checkbox"/> Frequent Headaches</p> | <p>Y N
 <input type="checkbox"/> Liver Disease / Yellow Jaundice
 <input type="checkbox"/> Kidney Failure/Disfunction
 <input type="checkbox"/> Thyroid Disease
 <input type="checkbox"/> Frequent Stomach Upset/Aches
 <input type="checkbox"/> Chemotherapy / Cancer
 <input type="checkbox"/> Asthma
 <input type="checkbox"/> Cough / Tuberculosis (TB)
 <input type="checkbox"/> A.I.D.S. / H.I.V.
 <input type="checkbox"/> Hepatitis: A B C (circle one)
 <input type="checkbox"/> Pain in Jaw Joint</p> | <p>Y N
 <input type="checkbox"/> Fever Blisters / Cold Sores Other
 <input type="checkbox"/> Fainting / Dizzy Spells
 <input type="checkbox"/> Epilepsy / Seizures
 <input type="checkbox"/> Hay Fever / Sinus Trouble
 <input type="checkbox"/> Allergies / Hives
 <input type="checkbox"/> Nervousness
 <input type="checkbox"/> Psychiatric Treatment
 <input type="checkbox"/> Drug / Alcohol Addiction</p> |
|--|--|---|

Is your child allergic to or reacted adversely to any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Metals/Jewelry | <input type="checkbox"/> Local/Dental Anesthetic |

Does your child have allergies to any other medications or substances? If yes, please list:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Steven J. Crawford and/or dental staff to perform the necessary dental services my child may need.

Parent/Guardian Signature _____ Date ____/____/____

Medical History Update

(For Office Use Only)

Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____
Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____
Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____
Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____