DENTAL/MEDICAL QUESTIONAIRE

Patients Name: _____

Has your child complained of any dental problems? Yes__ No__
If yes, please explain _____
Does your child have any habits such as thumb/finger sucking or pacifier? Yes__ No__
If yes, which one and how often? _____,_____
Does your child take fluoride? Yes __ No __ Does your child grind their teeth? Yes __ No __
Has your child ever had any injuries to his mouth or head? If yes, please explain:
_____
_____

Childs physician_____ Phone number_____
Date of last physical examination _____ Is your child under doctor's care now?_____
If so, for what reason? _____
Is your child taking any medication or drugs ? Yes __ No __Please list:_____
For what reason?
_____

Has your child ever been hospitalized? Yes __ No __When?_____
If yes, for what reason_____ _____
Does your child have an allergic reaction to food? ___ animals? ___ pollen?___ dust? ___ latex? ___
If so, please explain:_____

Are your child's immunizations up to date? Yes ___ No ___

Has your child had a history or difficulty with any of the following :

Yes	No		Yes	No		Yes	No	
___	___	Allergies to Medication	___	___	Bleeding Problems	___	___	Hearing difficulties
___	___	Premature Birth	___	___	Nosebleeds	___	___	Earaches
___	___	First Year of Life	___	___	Bruising	___	___	Gag Reflex
___	___	Heart Problems	___	___	Anemia	___	___	Motion Sickness
___	___	Rheumatic Fever	___	___	Hepatitis	___	___	Cancer or Malignancies
___	___	Asthma	___	___	Brain Injury	___	___	Kidney Problems
___	___	Seizures	___	___	Cerebral Palsy	___	___	Fainting or Dizziness
___	___	Diabetes	___	___	Bone Disorder	___	___	Speech Disorder
___	___	Immune Disorder/HIV/AIDS	___	___	Liver Problems	___	___	Reflux or Regurgitation
___	___	Tuberculosis	___	___	Delayed Development	___	___	Eczema

Comments/Details_____

The above statements are, to the best of my knowledge, true and correct. I agree to report any health changes to the dentist before any treatment is performed. _____
(initial)

_____