

"Your Child's Care is Our Focus!"

Patient's Name: _____

Health and Dental History

1. Is your child in good health? _____
2. Your child's physician's name and telephone number:

3. Has your child ever had a health problem? _____
4. Has your child ever been hospitalized? – reason and date

5. Is your child allergic to anything? _____
6. Is your child taking any medications? – list medications, dose and reason

7. Were there any problems at birth? _____

8. Please indicate if your child currently has or has ever had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Skin disease (e.g. eczema) |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Visual, hearing or sinus problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Malignant hyperthermia |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Infectious disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Speech or hearing problems |
| <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Congenital birth defects |
| <input type="checkbox"/> Eyesight problems | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Asthma/breathing problems |
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Endocrine/growth problems |
| <input type="checkbox"/> Social problems | <input type="checkbox"/> Autism | <input type="checkbox"/> Other |

Please explain: _____

9. Was your child breast fed or bottle fed? At what age did it stop? _____

10. Has your child ever been to a dentist? - list the name of the dentist and date

11. Has your child experienced unfavourable reaction from dental care? – explain

12. Does your child suck a finger, thumb or pacifier?

13. Is your child having any problems with any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Trauma/accident | <input type="checkbox"/> Crowding/orthodontics |
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Gums infections | <input type="checkbox"/> Jaw sounds |
| <input type="checkbox"/> Sensitive teeth | <input type="checkbox"/> Discoloured teeth/stains | <input type="checkbox"/> Other |

Please explain: _____

14. Does your child have any exposure to fluoride? - toothpaste, supplements, fluoride varnish at a public health unit? _____

I, the undersigned, verify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician being contacted if necessary to obtain information that is required for my child's dental care. I authorize the dentist to perform the diagnostic procedures that may be required to determine the necessary treatment and assume financial responsibility for dental services rendered for my child.

Parent/Guardian signature: _____ Date: _____

Reviewed by the dentist: _____ Date: _____