PATEL & DORNHECKER
DENTISTRY

CHILDRENS
MEDICAL HISTORY

Patient Name_____ DOB:_____

Dental History

1. Is this the child's first visit to a dentist?.....YES NO
2. Does the child snore?.....YES NO
3. Does the child grind teeth?.....YES NO
4. Are there issues with the tonsils (such as enlarged)…… YES NO
5. Does the child have any habits such as
   Pacifier / thumb / finger sucking?.....YES NO
6. Dos the child have a bottle or sipper cups or speech issues?.....YES NO
7. Do you live in an area without fluoridated water?.....YES NO
8. Has the child had any unfavorable dental experiences?.....YES NO

Explain_____

_____

Medical History

1. Is the child in good health?.....Y / N
2. The child had any serious illness?...Y / N

When?_____

What?_____

3. Has the child had surgery?.....Y / N
4. Subject to profuse bleeding?.....Y / N
5. Is the child subject to nervous
   Disorders…….....Y / N
   Seizures.....Y / N
   ADD/ADHA…….....Y / N
   Depression.....Y / N
   Anxiety……..….Y / N
   Dizziness?.....Y / N
   Fainting?.....Y / N
6. Does the child have allergies?.....Y / N
   Medications……..….Y / N
   What_____
   _____
   Latex…….……..Y / N
   Other_____

7. Does the child have any of the following problems?
   Heart Issues…….… …Y / N
   Liver…….……Y / N
   Kidney…….……Y / N
   Lung……..……Y / N

8. Is the child taking any medication? Y / N

What_____
_____

When_____

Why_____

Parent Signature_____ Date:_____