Child's Paintbrush Dental Medical History

Patient Name: Birth Date: Date Created:

Your child's mouth is a part of their entire body. Health problems that your child may have, or medications being taking, could have an important interrelationship with the dentistry they will receive

Is your child under a physician's care now? Who?	◯ Yes ◯ No	If yes
Has your child ever been hospitalized or had a major operation? Please list.	◯ Yes ◯ No	If yes
Has your child ever had a serious head or neck injury? Please describe.	◯ Yes ◯ No	If yes
Is your child taking any medications? Please list.	◯ Yes ◯ No	If yes
Does your child use tobacco? Please state if you chew, smoke or vape.	◯ Yes ◯ No	If yes

Does your child brush and floss?

☐ By self ☐ With adult help ☐ Both

☐ Once per day ☐ Two or more times per day ☐ Never

Has your child had:

☐ Previous dental visit ☐ Anesthetic ☐ Bad dental experience ☐ Nirtrous oxide/happy gas

☐ Hospitalization for dental treatment

Does your child eat/drink any of the following? If so, how often?

☐ Candy ☐ Soda ☐ Juice

☐ Raisins ☐ Fruit roll ups ☐ Fluoridated water

☐ Daily ☐ Monthly ☐ Less than once per month

☐ More than once per day

Does your child (have):

☐ Loose teeth ☐ Tooth pain ☐ Broken or chipped teeth

☐ Pain/popping in jaw joints ☐ Oral cancer or history of ☐ Cold sores/fever blisters

☐ Fear of dentist/treatment ☐ Fear of needles ☐ Grinding or clenching

☐ Frequent vomiting ☐ Acid reflux ☐ Decay/cavities

☐ Bleeding gums ☐ History of mouth/facial trauma ☐ Bad breath

☐ Tongue thrusting ☐ Speech problems ☐ Go to bed with a bottle

☐ Suck on thumb, finger or pacifier ☐ Trouble latching on when breast feeding ☐ Developmental delays

☐ Eating problems ☐ Gag reflex

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex

☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have or have you had any of the following?

Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Chemo/Radiation Treatments ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No
Hepatitis A, B OR C ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No
Sickle Cell Disease ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No
Stomach/Intestinal Disease ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Active tuberculosis ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No
Tumors or Growths ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Epilepsy or seizures ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Hearing loss ◯ Yes ◯ No
AIDS/HIV positive ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____