Name_____**Age**_____**Date**_____

CHILD'S MEDICAL AND DENTAL HISTORY

GENERAL HEALTH REVIEW **Please review your child's past and present health history. *Mark the box ONLY* if your child has the condition now or has been treated for the condition in the past.**

THE EYES, EARS, NOSE AND THROAT
- □ Allergies
- □ Chronic Earaches
- □ Deafness/Hearing Loss
- □ Speech Problems
- □ Chronic Sore Throat/Tonsillitis
- □ Tonsils/Adenoids Removed
- □ Blindness/Low Vision
- □ Other_____

ALLERGIES
- □ Allergy to food, food additives_____
- □ Allergy to household items, dust, pets
- □ Allergy to plants, pollen, grass
- □ Allergy to latex rubber
- □ Allergy to Drugs, Specify_____
- □ Other_____

THE STOMACH, LIVER, KIDNEYS, BLADDER
- □ Stomach Problems
- □ Diabetes
- □ Kidney Problems
- □ Hepatitis
- □ Bladder Problems
- □ Other_____

THE LUNGS
- □ Asthma Date of last attack_____
- □ Uses inhaler as needed
- □ Uses daily oral medicines or inhaler
- □ Uses steroids or has used steroids
- □ Bronchitis
- □ Pneumonia
- □ Tuberculosis
- □ Other_____

INFECTIONS AND SERIOUS ILLNESSES
- □ Immunizations are up-to-date
- □ Chicken Pox
- □ Chemotherapy Date(s)_____
- □ Hospitalization Date(s)_____
- □ Cancer or other malignancies Type_____

GROWTH AND DEVELOPMENT
- □ Premature birth- How early?_____
- □ Birth defects
- □ Concerns with growth
- □ Learning, behavioral, or communication problems
- □ Psychological problems, testing, counseling
- □ Alcohol, tobacco, or drug use

THE CIRCULATORY SYSTEM
- □ Heart Murmur
- □ Antibiotics for previous dental work
- □ Circulation Problems
- □ Congenital Heart Problems
- □ Heart Surgery
- □ Artificial Heart Valve
- □ Rheumatic or Scarlet Fever
- □ Excessive Bleeding/Hemophilia
- □ Hepatitis
- □ Sickle Cell Anemia
- □ HIV/AIDS
- □ Leukemia
- □ History of Blood Transfusion Date_____
- □ Other_____

THE NERVOUS SYSTEM, MUSCLES AND BONES
- □ Epilepsy or Seizure
- □ Fainting
- □ Cerebral Palsy
- □ Nervous Problems
- □ Mental retardation
- □ Autism
- □ Down Syndrome
- □ Attention Deficient Disorder
- □ Head Trauma/Brain Injury
- □ Spina Bifida
- □ Muscular Dystrophy
- □ Orthopedic Problems

Artificial Joints

Other_____

LIST ANY MEDICATIONS YOUR CHILD IS PRESENTLY TAKING

_____

_____

CHILD'S PHYSICIAN_____ **Phone #** _____

IS THERE ANYTHING ELSE WE NEED TO KNOW ABOUT YOUR CHILD'S HEALTH HISTORY?

_____

_____

(NEXT PAGE)

DENTAL HEALTH REVIEW Please review your child's past and present dental health for us.
Mark the box ONLY if your child has had the condition now or has been treated for the condition in the past.

FIRST VISIT INFORMATION (Only new patients and their parents need to complete this section)
□ THIS IS MY CHILD'S FIRST DENTAL VISIT
□ MY CHILD IS WORRIED ABOUT TODAY'S VISIT
□ MY CHILD'S PREVIOUS VISITS WERE UNSATISFACTORY
□ MY CHILD HAD AN ACCIDENT, HURTING THE HEAD, MOUTH, OR TEETH
□ MY CHILD HAS HAD A TOOTHACHE RECENTLY
When eating only OR Keeps him/her up at night (Please circle)

DENTAL HEALTH AND HABITS (Please mark only the boxes that apply to your child)
□ MY CHILD HAS HAD REGULAR DENTAL EXAMS AND CLEANINGS
□ LAST EXAM, CLEANING AND FLUORIDE TREATMENTS (DATE_____)
□ MY CHILD PRESENTLY TAKES A FLUORIDE SUPPLEMENT
□ DENTAL X-RAYS WERE TAKEN AT EARLIER VISITS WITH DR._____
□ MY CHILD WAS BREAST OR BOTTLE FED FOR MORE THAN 1 YEAR
□ MY CHILD SLEPT WITH A BABY BOTTLE. (What was in the bottle?_____)
□ MY CHILD SUCKS A THUMB OR FINGERS
□ MY CHILD USES A PACIFIER
□ MY CHILD IS A MOUTH BREATHER
□ MY CHILD GRINDS or CLINCHES TEETH
□ INJURY TO MOUTH AND/OR TEETH
□ BLEEDING GUMS
□ ARE THERE ANY OTHER DENTAL CONCERNS TO YOU AS A PARENT?
_____
_____
_____

HOW OFTEN ARE YOUR CHILD'S TEETH BRUSHED PER DAY?
□ ONCE
□ TWICE
□ AFTER EACH MEAL
□ NONE

WHAT TYPE OF TOOTHPASTE DOES YOUR CHILD USE? _____

DO YOU HELP YOUR CHILD FLOSS DAILY? Yes or No

WHAT IS YOUR FAMILY'S WATER SUPPLY?
□ Well
□ Public system
□ Bottled/distilled

Thank you for your help. If there is any information you think might be of value to us in treating your child, please feel free to comment.
I certify that I have read and understand the above questions. I will not hold Dr. Reese, her associates and other healthcare professionals on her staff responsible for any errors or omissions I may have made in the completion of this form.

Signature of Parent or Legal Guardian **Relationship to patient** **Date**

_____

Witness **Date**

_____

REVIEWED BY DR. VALERIE REESE ON __/ __/___ ___