CHILD HEALTH/DENTAL HISTORY FORM

Is this the patient's first visit to the Dentist? ___ Yes ___ No If no, when was the last visit? _____

Were there xrays taken? ___Yes ___No If yes, when? _____

Name of Previous Dentist: _____ Phone: _____

Please describe Patient's dental problem(s): _____
_____

Please check any of the following that may describe the patient's attitude towards dentistry:
___ Cooperative ___ Friendly ___ Anxious ___ Shy ___ Uncooperative

Is the patient in good health? ___Yes ___No

Does the patient have any of the following habits?

	YES	**NO**
Nursing bottle	___	___
Nail biting	___	___
Thumb/finger sucking	___	___
Teeth grinding	___	___
Cheek/lip biting	___	___
Jaw clenching	___	___
Mouth breathing	___	___
Pacifier	___	___

Other (Please Specify): _____

Medications:_____
_____

Drug Allergies:_____
_____

Does patient have or has patient ever had the following conditions? Circle all that apply

Arthritis	Anxiety/Nervousness	Anemia	Cancer
Asthma	Autism	Bleeding (Prolonged)	Fainting
Diabetes	Emotional Disability	Hemophilia	Gag reflex
Heart Disease	Psychiatric Disorder	Brain Injury	Headaches
Kidney Disease	Hepatitis	Cerebral Palsy	Hearing loss
Rheumatic Fever	HIV Infection	Cleft lip/palate	Speech Problems
ADHD	Tuberculosis	Seizures	Other _____

Further details: _____

Parent or Legal Guardian Signature: _____

Child's Name: _____Date: _____