

Mobile Dental Clinic

# Medical/Dental History Form for Children

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Male**:[ ]  **Female**: [ ]

**Family Physician’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Physician’s Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is patient under treatment by a physician? Yes No
2. Has this patient had any serious illnesses, surgeries or been hospitalized? Yes No

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any medications & the dosage this patient is taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Allergies: [ ]  None [ ]  Penicillin [ ]  Sulfa Drugs [ ]  Latex [ ]  Codeine [ ]  Local Anesthetic

[ ]  Other antibiotics \_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Artificial food, flavors, colors [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has this patient’s physician/dentist ever prescribed antibiotics prior to a dental appointment? Yes No
2. Is this patient disabled? [ ]  No [ ]  Yes If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Has this patient ever had any history of the following? If yes, check the appropriate space. If No, check here [ ]

[ ]  Autoimmune disease [ ]  Heart Valve Replacement or Mitral Valve Prolapse [ ]  HIV

[ ]  Anemia [ ]  Heart Murmur [ ]  Psychiatric Disorders

 [ ]  Asthma [ ]  Kidney or liver disease [ ]  Diabetes

[ ]  Bleeding disorders [ ]  Lung disease / Bronchitis [ ]  Tuberculosis

[ ]  Childhood disease [ ]  Seizures/ Epilepsy/ Fainting [ ]  Other:

(Mumps, measles) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. Has this patient ever had any history of the following oral habits?

[ ] Pacifier [ ]  Mouth breathing [ ]  Grinds/clench teeth [ ]  Thumb/finger sucking [ ]  Nail Biting

1. Has this patient ever had an injury to the head, face, or jaw? [ ]  No [ ]  Yes- Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is the drinking water source for this patient? Please check the appropriate space.

[ ]  city water [ ]  well water [ ]  bottle water [ ]  filtered water [ ]  Unsure

1. Is this the first dental visit ever for this patient? Yes No
2. Is this patient experiencing any: [ ] pain/discomfort [ ] swelling [ ]  toothaches? Check all that apply
3. How does this patient feel about going to a dentist? Please circle: Scared Apprehensive No problem

**Important! Parent/legal guardian signature required:**

I certify that I have read and understood the above questions. To the best of my knowledge the above information is correct and accurate. I will not hold the Northwest Community Healthcare, treating dentist(s) or any member of the dental staff responsible for any errors or omissions I may have made in the completion of this form. I understand that it is my responsibility to inform my child’s dentist when there is a change in my child’s medical condition, or when there is a change in the responses to any of the above questions.

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_