

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_