

5. Has your child taken any unusual medications in the past? Yes No
 If so, what? _____ For what reason? _____
6. Has your child shown any allergies or unusual reactions? Please describe. Yes No
 a. Medications or drugs _____
 b. Foods _____
 c. Other _____
7. Has your child ever been hospitalized? Yes No
 If so, when? _____
 For what reason? _____
8. Has your child had any operations? Yes No
 If so, when? _____
 For what reason? _____
 Was general anesthesia used? Yes No
 Any complications, if so, what? _____
9. Are your child's immunizations up-to-date? Yes No
10. Does your child have any history of the following diseases or conditions? (If "yes" check boxes that apply) Yes No
- | | | |
|--|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sickle Cell Disease or Trait |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Bleeding Problem | <input type="checkbox"/> Leukemia or Tumors |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Past Hx of Child Abuse | <input type="checkbox"/> HIV |
- Heart Murmur, Type? _____
 Learning Disabilities, Type? _____
 Emotional Disabilities, Type? _____
 Hearing Difficulty, Type? _____
 Speech Difficulty, Type? _____
 Developmental Disability or Delay, Type? _____
 Other _____
11. Does your child bruise easily? Yes No
12. Has there ever been any history of spontaneous bleeding (e.g., nose bleeds) or prolonged bleeding following tooth removal surgery, cuts, etc.? Yes No

REMARKS: _____

DENTAL HEALTH HISTORY

1. Please check reason(s) for seeking dental care
- | | |
|--|--|
| <input type="checkbox"/> First Examination | <input type="checkbox"/> Appearance of teeth or face |
| <input type="checkbox"/> Routine check-up | <input type="checkbox"/> Crowding of teeth |
| <input type="checkbox"/> Toothache or swelling | <input type="checkbox"/> Accident |
| <input type="checkbox"/> Other _____ | |
2. If your child has been to a dentist previously Yes No
 a. When was last visit? _____
 b. Have x-rays been taken and when? Date _____
 c. How would you describe your child's temperament? _____
3. How do you think your child would react to dental treatment? _____

4. Has your child had fluoride in any of the following forms? Yes No
 fluoride tablets or in vitamins (Fluoride amt. **.25 .5 1.0 mg**) Yes No
 Drinking water (community fluoridation) Yes No
 Topical application to teeth; last _____
 Toothpaste; brand _____

