Dental / Medical History Form

Last Name: ______________ First Name: ______________ Birthdate: ______________

Name of Medical Doctor: ______________________ City/Prov: ______________

Emergency Contact ______________ Phone __________ Relationship ______________

Dental History

Does your child have any of the following habits?

- ☐ Thumb or finger sucking
- ☐ Mouth breathing
- ☐ Nail Biting
- ☐ Pacifier
- ☐ Grinding/clenching
- Other: ______________

What kind of toothpaste do you use?

- ☐ With fluoride
- ☐ Without fluoride
- ☐ Not sure

Does your child have a history of cavities, trauma to teeth, or other dental problems? If yes, please describe.

Does your child sleep with a bottle or sipped cup? (ages 5 and under). If yes, please describe.

Has your child ever undergone orthodontic treatment? If yes, please describe and list name of orthodontist.

Has your child ever had a difficult dental appointment? If yes, please explain.

Is there anything else concerning you about your child's teeth or that we should know before treating your child?

Has your child had recent dental X-rays? If yes, please estimate the date. ______________

Name and location of former dentist: ______________________________

Medical History

Is the patient in good health or do they have any medical conditions?

Please list any medical conditions for which the patient is currently being treated.

Within the past year, have there been any changes in the patients general health? If yes, please explain.

What is the date (or approximate date) of the patients last medical exam?

Is the patient currently taking any medications (including inhalers)? If yes, please list current medications.

Please list any medical conditions that the patient has been treated for in the past.

Does the patient have any drug allergies? If yes, what drug(s) and what occurs? (rash, hives, swelling, breathing problems?)

Does the patient have any food allergies? If yes, what food(s)?

Does the patient smoke? If yes, what do they smoke? How much do they smoke? How long have they smoked?

Has the patient been hospitalized before? If yes, please explain.

Does the patient have a family history of cardiomyopathies (heart failure), or have any family members experienced heat failure while they were young (teens or 20s)?

Does the patient have history of violent, aggressive, or abusive behaviour? Are they prone to outbursts? If yes, please explain.

WOMEN ONLY Is the patient pregnant? Could they be pregnant? If yes, when is the due date?

WOMEN ONLY Does the patient use oral contraceptives?

Does the patient have any of the following medical conditions?

Y	N	Condition
☐	☐	Antibiotics required prior to dental appointment
☐	☐	Rheumatic heart disease / endocarditis
☐	☐	Heart attack
☐	☐	Pacemaker
☐	☐	Stroke
☐	☐	Fainting or light headedness
☐	☐	Anxiety or depression
☐	☐	ADHD
☐	☐	FASD
☐	☐	Substance dependence
☐	☐	Breathing problems
☐	☐	Bronchitis
☐	☐	COPD
☐	☐	Lung disease
☐	☐	Thyroid condition
☐	☐	Immune problems
☐	☐	Stomach ulcers
☐	☐	Digestive problems
☐	☐	Seizures
☐	☐	Fainting spells
☐	☐	Arthritis
☐	☐	Abnormal bleeding or bruising
☐	☐	Any blood borne diseases
☐	☐	Jaundice or liver disease
☐	☐	Glaucoma
☐	☐	Steroid treatment in the past 2 years

Y	N	Condition
☐	☐	Previous heart valve repair / heart surgery
☐	☐	Chest pain
☐	☐	Heart murmur / irregular heart beat
☐	☐	High blood pressure
☐	☐	Heart palpitations
☐	☐	Tuberculosis
☐	☐	Past or current mental illness
☐	☐	ODD
☐	☐	Developmental delay
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Chronic cough
☐	☐	Sinus troubles
☐	☐	Diabetes
☐	☐	Kidney disease
☐	☐	Acid reflux / GERD
☐	☐	Frequent nausea / vomitting
☐	☐	Special diet from physician
☐	☐	Headaches / migranes
☐	☐	Muscular dystrophy
☐	☐	Mobility difficulties
☐	☐	Frequent nose bleeds
☐	☐	Hepatitis
☐	☐	Blood disorders or anemias
☐	☐	Cancer or benign tumor

Another disease / condition not mentioned above? ______________________

Additional Comments ______________________

____

Patient/Parent/Guardian Signature: ______________________

Date:
2021-03-04