| Derital Filstory   |  | Medical P  | iisiory   |
|--|--|--|---|
| Why did you bring the child to the dentist today?  |  | Has the child experienced the f  | ollowing medical problems?  |
| Triff and you bring the arma to the definish loady:  | -  |  | Y N Heart Murmur  |
|  |  | 100/1010   | The last telephone to the last  |
| Has the child ever taken any diet pills such as Phen-Fen?  |  | Y N ADD/ADHD Y N AIDS/HIV+   | Y N High Blood Pressure   |
| (Also known as Redux or Pondimin.) If so, when?  | ☐ Yes ☐ No   | Y N Anemia   | Y N Hives   |
| Is the child currently in pain?  | ☐ Yes ☐ No   | Y N Any Hospital Stays/Operations?   | Y N Kidney Problems   |
| Does the child require antibiotics before dental treatment?  | ☐ Yes ☐ No   | Y N Artificial Bones/Joints/Valves   | Y N Liver Problems  |
| Has the child ever had a serious/difficult problem associate   |  | Y N Asthma<br>Y N Cancer   | Y N Low Blood Pressure<br>Y N Lupus   |
| previous dental work?  | ☐ Yes ☐ No   | Y N Chicken Pox  | Y N Measles   |
| Is the child's water fluoridated?  | ☐ Yes ☐ No   | Y N Congenital Heart Defect  | Y N Mitral Valve Prolapse   |
| Is the child taking fluoridated supplements?   | ☐ Yes ☐ No   | Y N Convulsions  | Y N Mononucleosis   |
| Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?   | ☐ Yes ☐ No   | Y N Diabetes Y N Epilepsy  | Y N Prosthetics Y N Rheumatic Fever   |
| Does the child brush his/her teeth daily?  | ☐ Yes ☐ No   | Y N Exposed to HIV, but Neg.   | Y N Scarlet Fever   |
| Floss his/her teeth daily?   |  | Y N Handicaps/Disabilities   | Y N Skin Rash   |
|  | ☐ Yes ☐ No   | Y N Hearing Impairment   | Y N Tuberculosis (TB)   |
| Child's Physician:   |  | Are the child's immunizations current?   | ☐ Yes ☐ No  |
| Phone #: Date of Last Visit:   |  | Anything you would like to discuss with the  | ne Doctor in private? 🗆 Yes 🗀 No  |
|  | ☐ Yes ☐ No   | Please discuss any serious medical proble  |   |
| Please describe the child's current physical health:   | ☐ Fair ☐ Poor  | 7  |   |
| Please list all prescription / over the counter or herb  |  |  |   |
|  |  | Does/did the child experience any of the   | following?  |
| drugs that the child is currently taking:  |  |  | Y N Nursing Bottle Habits   |
| A-1-7 - 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1  | ldt. n .   | Y N Chewing on Objects   | Y N Speech Problems   |
| Aside from items listed inlease list all drugs (things that the  | child is allergic to:  | Y N Clenching/Grinding Teeth   | Y N Thumb/Finger Sucking  |
| Aside from items listed, please list all drugs/things that the   |  | , , cionannig, ormanig reem  | V V T /C    D::   |
|  | -  | Y N Lip Sucking/Biting   | Y N Tongue/Cheek Biting   |
|  |  | Y N Lip Sucking/Biting Y N Mouth Breather  | Y N Tongue Thrust   |
|  | No Plastic   | Y N Lip Sucking/Biting   |   |
| Yes No Latex Yes No Metals/Nickel Yes N  |  | Y N Lip Sucking/Biting Y N Mouth Breather Y N Nail Biting  | Y N Tongue Thrust<br>Y N Used Pacifier  |
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