Davies
Pediatric Dentistry

MEDICAL/DENTAL HISTORY

Patient's Name _____ (circle) M F Patient's Birthdate ____ /____/_____

ANY HISTORY OF ANY OF THE FOLLOWING: *(Please circle* Y *(yes) or* N *(no))*

Y N AIDS or HIV infection
Y N Asperger's Syndrome
Y N Asthma
Y N Attention Deficit Disorder
Y N Autism
Y N Bleeding Problems
Y N Blood Disorders
Y N Blood Transfusion
Y N Cancer
Y N Cerebral Palsy
Y N Chemotherapy
Y N Chronic Sinus
Y N Cognitively Disabled
Y N Diabetes
Y N Down Syndrome
Y N Epilepsy
Y N Fainting Spells
Y N Hearing Loss
Y N Heart Condition/Murmur
Y N Hepatitis
Y N Kidney Disease
Y N Liver Disease
Y N Phen-Fen Use
Y N Pregnant
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Seizures
Y N Sickle Cell Anemia
Y N Thyroid Problems
Y N Tuberculosis
Y N Other – If yes, please explain below

Please list any other problems/conditions your child has that we should be aware of but have not discussed_____
_____

Physician's Name _____

Is your child presently taking any medication? Y N If yes, please list medication and reason for taking.
Med _____ Reason _____
Med _____ Reason _____

Does your child require premedication with antibiotics prior to dental treatment? Y N

Is your child allergic to latex? Y N

Is your child allergic to any medications or drugs? Y N If yes, please list_____

Please list any other allergies _____

Hospitalization (other then birth):
Date (or age) _____ Reason _____

Is this your child's first dental visit? Y N
If no, date or age, of last dental visit and the previous dentists name _____

Is your child complaining of a dental problem? Y N If yes, please explain _____

Has your child had any unhappy dental experiences? Y N If yes, please explain _____

Has your child had any dental injuries? Y N If yes, please explain _____

Oral Habits

Y N Thumb sucking
Y N Finger sucking
Y N Pacifier use
Y N Nursing or bottle habit
Y N Nail biting
Y N Lip biting
Y N Grinding of teeth
Y N Mouth breathing

Are orthodontic appliances worn now or ever been worn? Y N If yes, please list the orthodontist _____

Any other information you think would be valuable to Dr. Davies _____

I certify that I have read and understood the above. I acknowledge that I have completed this form to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history or medical status of my child, I will inform the dentist. I authorize the dentist and dental staff to perform the necessary dental services for my child.

Signature of parent or legal guardian _____ Date_____/_____/_____