LIANN W. DRECHSEL, DMD, PC

PEDIATRIC DENTISTRY

HEALTH HISTORY

A-DENTAL HISTORY **Patient Name: _____ Date: _____**

Date of last visit to a dentist_____ Has your child complained about any dental problems? Yes/No Have there been any unhappy dental experiences for your child? Yes/No For you? Yes/No Does your child dislike going to the dentist? Yes/No Do you? Yes/No
Has your child had any injuries to the mouth, teeth or head? Yes/No Type of injury _____
Summary (DOCTOR USE) _____

Does your child brush regularly? Yes/No Do you Assist? Yes/No How often? _____ Is dental floss used in your family? Yes/No
If yes, who?_____ Are disclosing tabs used? Yes/No If yes,who?_____
Is fluoride taken? Yes/No If yes, how? Perscription/Toothpaste/Mouthwash Is xylitol used? Yes/No If yes, who? _____
What is your childs attitude toward dentistry? _____

Do you desire complete dental service for your child? Yes/No If No, please explain _____

B- MEDICAL HISTORY

Is your child in good health? Yes/No If No, please explain_____

Have you ever been told your child has a heart murmur? Yes/No Does your child have regular medical exams? Yes/No Date of last exam _____

Reason for exam_____ Has your child ever been hospitalized? Yes/No

Reason for Hospitalization _____

Has your child ever experienced an unfavorable reaction to drugs, including antibiotics or local anesthesia? Yes/No If yes, please explain____
_____

Does your child have car/motion sickness? Yes/No Do you consider your child to be: (Please choose one of the following)

Advanced in the learning process Progressing normally A slow learner

Were there any problems in the birth of this child? Y/N If yes, please explain _____

Is your child taking any medications? Y/N If yes, please list _____

Has your child had any history of difficulty with any of the following? **Please circle all that apply/If none apply mark here:** _____

ADD/ADHD	BLEEDING DISORDER	DEVELOPMENTAL DELAY	HEART	MEASLES/MUMPS	
AIDS/ARC	CANCER/TURMOR	DIABETES	HEPATITIS	MENTALLY HANDICAPPED	
ANEMIA	CEREBRAL PALSY	DOWN SYNDROME	KIDNEY	MRSA	
ASTHMA	CHICKEN POX	EPILEPSY	LIVER	OSTIOPOROSIS	
AUTISM	CHRIONIC SINUS	FAINTING	LUNGS	SEIZURES	THYROID
BLADDER	CONVULSIONS	HEARING	MALIGNANCIES	SLEEP APNEA	TUBERCULOSIS

Other: _____ Are your/your child's immunizations current? Y/N _____

PRIMARY CARE PHYSICIAN /PEDIATRICIAN _____ PHONE#_____

C-Update

Legal guardian name _____ **Relationship to patient** _____

Signature _____ **Date**_____

Address:_____ **Phone #:** _____

Primary Insurance: _____ **Secondary Insurance:** _____

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