LIANN W. DRECHSEL, DMD, PC
PEDIATRIC DENTISTRY

HEALTH HISTORY

PATIENT INFORMATION

FIRST NAME: _____LAST NAME: _____ DOB:_____/_____/_____

DENTAL HISTORY

Date of last visit: _____/_____/_____ Has your child complained of any dental problems? Y / N

Have there been any unhappy dental experiences for your child? Y / N For you? Y / N Does your child dislike going to the dentist? Y / N Do you? Y / N

Has your chld had any injuries to the mouth, teeth, or head? Type of injury_____

Summary of injury (DOCTOR USE):_____

Does your child brush regulary? Y / N Do you assist? Y / N How often: _____

Is dental floss used in your family? Y / N If yes who?: _____ Are disclosing tabs used? Y / N If yes who? _____

Is flouride taken? Y / N If yes how? Prescription / Toothpaste / Mouthwash Is xylitol used? Y / N If yes who? _____

Do you desire complete dental service for your child? Y / N If no, please explain:_____

MEDICAL HISTORY

Is your child in good health? Y / N if not please explain: _____

Have you ever been told that your child has a heart murmur? Y / N Does your child have regular medical exams? Y / N

Date of last exam:_____/_____/_____Reason for exam: _____

Has your child ever been hospitalized? Y / N If yes, reason for Hospitalization: _____

Does your child have car/motion sickness? Y / N Has your child ever experienced an unfavorable reaction to drugs, including antibiotics or local anesthesia? Y / N

If yes, please explain: _____

Do you consider your child to be: (please circle): Advanced in the learning process / Progressing normally / A slower learner

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

Is your child taking any medication? 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 PLEASE CHECK HERE:** ❑

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

OTHER _____ Are your/your child's immunizations current? Y / N PCP/PEDIATRICIAN: _____

Legal Guardian Name: _____ Relationship to patient: _____

Mailing Address_____City_____Zip _____ Phone #: _____-_____-_____

Prim Ins/ID:: _____ 2nd Ins/ID#:_____ Employer: _____

SIGNATURE: _____ **Date:** _____/_____/_____