

PATIENT NAME _____ DATE _____

DENTAL HISTORY

Previous Dentist's name _____ Phone _____
Is this your child's first visit to a dentist? _____ If no, date of last dental visit _____
Date of last x-rays _____ Treatment completed at last dental visit _____
Is there anything about your child's dentistry or dental health that you'd like us to be aware of?

TMJ SCREENING

Has your child ever had a problem with their jaw joints (TMJ's)? Y N
Has your child ever been injured by a blow to the jaw? Y N
Does your child ever complain of jaw pain or tenderness when they chew or talk? Y N
Does your child complain of tenderness when they open wide? Y N
Does your child's jaw ever make any clicks, pops, or grating sounds? Y N
Does your child complain of frequent headaches? Y N If so, how often, where? _____
Has your child's jaw ever locked open? Y N Locked closed? Y N Does your child have difficulty opening? Y N
Has your child ever been treated for a TMJ problem? **BITE SPLINT MEDICATION SURGERY**
ORTHODONTICS PHYSICAL THERAPY EQUILIBRATION COUNSELING

MEDICAL HISTORY

Physician's Name _____ Phone _____
Has your child ever been hospitalized or had a major operation? Y N Explain _____
Is your child taking any medications, pills, or drugs? Please list names / dosages

Does your child have any allergies to: **ASPIRIN PENICILLIN CODEINE ACRYLIC LATEX SULFA OTHER**
Does your child need an antibiotic pre-medication prior to dental work? Y N

Does your child now have or has ever had any of the following:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Allergies/Hives	<input type="checkbox"/> Cortisone Treatment	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Reflux/Indigestion
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Cough	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Artificial Heart	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Intestinal Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> GERD	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Other _____

Has your child had any serious illness/medical condition not listed above? Y N

Do you wish to talk privately to Dr. Brown about any concern/problem? Y N

To the best of my knowledge, all of the preceding answers are correct. If there are any changes in my child's health status or if medicines change, I shall inform the dentist and staff at their next appointment.

_____ Date _____

(Parent/Guardian Signature)

Reviewed by Doctor _____