NORTH OAKLAND DENTAL GROUP

Child Medical/Dental History

Patient Name: _____ Birth Date: _____

Parent/Guardian Name:_____ Relationship to Patient:_____

Name of Physician: _____ Physician Phone # _____

Is your Child allergic to or had a reaction to:

Aspirin, Ibuprofen, Acetaminophen, Codeine (circle)	Y N
Penicillin, Augmentin, Keflex, Erythromycin (circle)	Y N
Tetracycline, Sulfa, Bactrim (circle)	Y N
Local anesthetics	Y N
Fluoride	Y N
Metals: Nickel, Gold, Silver (circle)	Y N
Latex	Y N

Other: _____

Does the child need premedication (antibiotics) prior to dental appointment? Y N

Has the child ever used nitrous oxide for dental treatment? Y N

Child's History

Has the child ever been hospitalized?	Y N
Has the child ever received general anesthetic?	Y N
Does the child have any speech difficulties?	Y N
Is this the child's first dental visit?	Y N
Has the child ever had dental x-rays?	Y N
Has the child ever suffered any injuries to the mouth?	Y N
Has the child ever had any orthodontic treatment?	Y N
Does the child use a fluoride toothpaste?	Y N
Does the child take a fluoride supplement?	Y N
Does the child suck his/her thumb or fingers?	Y N
Does the child use a pacifier?	Y N
Does the child brush/floss his/her teeth on their own?	Y N
Does the child snore?	Y N

Other:_____

Does Your Child Have or Ever Had:

Autism	Y N
ADD / ADHA	Y N
Anemia	Y N
Asthma	Y N
Bleeding Disorders	Y N
Cancer	Y N
Cerebral Palsy	Y N
Chicken Pox	Y N
Diabetes	Y N
Epilepsy	Y N
Fainting	Y N
Growth Problems	Y N
Hearing loss	Y N
Heart (congenital abnormality/defect)	Y N
Hepatitis	Y N
HIV	Y N
Kidney Disorder	Y N
Liver Disorder	Y N
Malignant Hypothermia	Y N
Measles	Y N
Mumps	Y N
Rheumatic Fever	Y N
Seizures	Y N
Tuberculosis	Y N

List all medications, supplements and vitamins your child is currently taking:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient or Parent/Guardian's Signature: _____ Date: _____