CEDAR CREEK DENTAL

Dr. Jared Crutcher

CHILD MEDICAL/ DENTAL HISTORY

Patient's Name: _____

Last First Nickname Date of Birth

Medical History

1. Does your child have any health problems? ..... YES NO
2. Is your child under care of a physician? ..... YES NO
3. Name of physician: _____
4. Is your child receiving any medication? ..... YES NO
   If so, please list medications: _____
5. Is your child allergic to penicillin/antibiotics? ..... YES NO
6. Is your child allergic to or sensitive to any metals or latex? ..... YES NO
7. Does your child have other allergies? ..... YES NO
8. Has your child had any serious illness? ..... YES NO
   When _____ What _____
9. Has your child ever had surgery? ..... YES NO
10. Does your child have a heart murmur? ..... YES NO
    If yes, is surgery contemplated? ..... YES NO
11. Does your child experience severe or prolongated bleeding? ..... YES NO
12. Does your child have AIDS or tested HIV positive? ..... YES NO
13. Has your child tested positive for Hepatitis? ..... YES NO
14. Is your child subject to nervous disorders? ..... YES NO
    Fainting? ☐ Seizures? ☐ Dizziness? ☐
15. Does your child have behavioral/learning problems? ..... YES NO
16. Does your child have frequent headaches? ..... YES NO
17. Has your child had a history of (Circle appropriate answers):
    Diabetes, Heart trouble, Asthma, Kidney Infection, Rheumatic fever,
    Epilepsy, Cerebral Palsy, Liver Problems, Congenital Birth Defects, Cancer,
    Intellectual Disability, Eyesight Problems, Infections, Hearing Loss

Dental History

1. Is this your child's first visit to a dentist? ..... YES NO
2. If not, how long since their last visit to the dentist? _____
3. Were any x-rays taken at any of their appointments? ..... YES NO
4. Does your child indulge in sweets/candy/soda/gum? ..... YES NO
5. When does your child brush his/her teeth? _____
6. Has your child received fluoride (Circle): Well water, Fluoride Gel, None
7. Has your child been diagnosed or treated for cavities in the past? ..... YES NO
8. Has there been any injury to the teeth such as falls, blows, chips? ..... YES NO
9. Has your child had any trouble with dental treatment in the past? ..... YES NO
10. Has anyone in the family, including parents, had orthodontics? ..... YES NO
11. Has your child ever received local anesthetic? ..... YES NO
12. Has your child ever had occlusal sealants placed? ..... YES NO
13. Do you or your child have any issues with his/her teeth? ..... YES NO
    If yes, please list concerns: _____

COMMENTS:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Parent/Guardian Signature: _____ DATE _____

UPDATED MEDICAL HISTORY: *I have reviewed and confirmed/made changes to the above information as necessary.*

INITIAL/DATE: _____ INITIAL/DATE: _____ INITIAL/DATE: _____