DENTAL HISTORY

Is this your child's first dental visit? ❑ Yes ❑ No
Previous Dentist's Name? ____________________
Date of last visit: __________
Does your child feel nervous about having dental treatment? ❑ Yes ❑ No
Has your child ever had a bad dental experience? ❑ Yes ❑ No
Has your child been seen by an orthodontist? ❑ Yes ❑ No

Have there been any injuries to your child's teeth or jaws? Falls? Blows? Chips? etc? ❑ Yes ❑ No
Has your child ever been premedicated for dental work? ❑ Yes ❑ No
Does your child receive fluoride in vitamins, tablets, or water? ❑ Yes ❑ No

HEALTH HISTORY

Is your child having any pain or discomfort at this time? ❑ Yes ❑ No
Has your child been hospitalized during the past 2 years? ❑ Yes ❑ No
Has your child been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No
Physician Name ____________________
Address ____________________ Phone: __________

Is your child currently taking any medications? ❑ Yes ❑ No
If yes, please list: ____________________
Has your child taken any medicine / drugs during the past 2 years? ❑ Yes ❑ No
If yes, please list: ____________________
Please list any serious medical condition(s) that your child has or has had: ____________________
____

Please check "Yes or No" to the following conditions:

Y N
❑❑ High / Low Blood Pressure
❑❑ Congenital Heart Defect
❑❑ Heart Murmur / Rheumatic Fever
❑❑ Heart Surgery
❑❑ Diabetes
❑❑ Blood Transfusion / Anemia
❑❑ Sickle Cell Disease
❑❑ Bruise Easily
❑❑ Hemophilia
❑❑ Frequent Headaches

Y N
❑❑ Liver Disease / Yellow Jaundice
❑❑ Kidney Failure/Disfunction
❑❑ Thyroid Disease
❑❑ Frequent Stomach Upset/Aches
❑❑ Chemotherapy / Cancer
❑❑ Asthma
❑❑ Cough / Tuberculosis (TB)
❑❑ A.I.D.S. / H.I.V.
❑❑ Hepatitis: A B C **(circle one)**
❑❑ Pain in Jaw Joint

Y N
❑❑ Fever Blisters / Cold Sores
❑❑ Fainting / Dizzy Spells
❑❑ Epilepsy / Seizures
❑❑ Hay Fever / Sinus Trouble
❑❑ Allergies / Hives
❑❑ Nervousness
❑❑ Psychiatric Treatment
❑❑ Drug / Alcohol Addiction

Other
____
____
____
____
____
____

Is your child allergic to or reacted adversely to any of the following?

❑ Antibiotics
❑ Codeine
❑ Metals/Jewelry
❑ Aspirin
❑ Latex
❑ Local/Dental Anesthetic

Does your child have allergies to any other medications or substances? If yes, please list:

____
____
____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Paul McGriff and/or dental staff to perform the necessary dental services my child may need.

Parent/Guardian Signature ____________________ Date ___/___/___

Medical History Update

(For Office Use Only)

Date ______ Comments ____________________
Parent's Signature ____________________
Date ______ Comments ____________________
Parent's Signature ____________________
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