PATIENT
MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____
(Nickname:_____)
Date of Birth: _____ Sex: _____ Height: _____ Weight: _____
Previous Dentist: _____ Physician: _____
Whom may we Thank for referring you: _____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD:

____Heart Problems	____Sinus Trouble	____Blood Disorder	___ Autistic
____Heart Murmur	____Fainting Spells	____Epilepsy Or Seizures	
____Rheumatic Fever	____Diabetes Type I or II	____Tumor/Cancer	
____Cerebral Palsy	____Anemia	____Radiation/Chemotherapy	
____Tuberculosis	____Hemophilia	____AIDS or HIV+	
____Asthma	____Hearing	____Blood Transfusion	

OTHER MEDICAL PROBLEMS: _____

LIST ALL PREVIOUS HOSPITALIZATIONS/SURGERIES: _____
_____

PROBLEMS WITH PREVIOUS GENERAL ANESTHESIA/IV SEDATION: _____

CURRENT MEDICATIONS: _____

ALLERGIES TO MEDICATION: _____
ALLERGIC TO LATEX: _____ ALLERGIC TO SOY OR EGG: _____

CHILD'S DENTAL HISTORY

Is this your child's first dental visit? _____
If not, date of last visit to a dentist_____
Why did you leave your last dental office?
_____
What did you like *least* of any dental office?
_____
What did you like *most* of any dental office?
_____
What are you expecting to have done today?
_____
On a scale from 1 (bad) to 5 (perfect), what state are your child's teeth?
_____

Does your child brush teeth daily? _____
Do you assist with tooth brushing? _____
If so, how often?_____
Is dental floss used?_____
Child's attitude to dentistry_____
Any unhappy dental experiences?
_____
Any injuries to mouth, teeth, or head?_____
Any mouth habits – thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.?_____

IS THERE ANY OTHER CONDITION CONCERNING YOUR CHILD'S HEALTH THAT YOUR DOCTOR SHOULD BE AWARE OF? _____

I have read and fully understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully. I will not hold The Smiley Tooth nor any member of its staff, responsible for any errors or omissions that I have made in the completion of this form.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____