LAKES PEDIATRIC DENTISTRY HISTORY

(to be completed by parent or guardian)

_____
TODAY'S DATE

Child's Full Name _____ Birth Date _____ Age _____ Sex _____

Is child regularly seen by a medical doctor? Yes No Date of last exam _____

Name and address of doctor or clinic _____

Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Yes No

If yes, state the reasons _____

Why do you want dental care for your child? _____

MEDICAL HISTORY

Has your child ever had the following conditions?

Check			
Yes	No	?	
			Frequent colds or ear infections
			Strep throat or tonsillitis
			Pneumonia or respiratory problems
			Tuberculosis
			Allergies
			Asthma
			Eye problems
			Stomach problems or frequent vomiting
			Liver disease, hepatitis or jaundice
			Diabetes
			Birth defect
			Learning disorder
			Heart murmur or disease
			Regular injections or medications

If yes, list _____

Check			
Yes	No	?	
			Sickle cell anemia or trait
			Transfusions
			Bruises easily or bleeds a lot
			Scarlet fever or rheumatic fever
			Measles, mumps, or chicken pox
			Sexually transmitted disease
			AIDS, ARC
			Immunological problems
			Seizures or epilepsy
			Emotional or behavioral problems
			Pregnancy
			Drug or alcohol abuse
			Use of tobacco products
			Physical abuse

Other problems _____

IMMUNIZATIONS

Has your child had the following immunizations?

Check			
Yes	No	?	
			DPT
			Oral polio
			Tetanus booster
			Measles

Check			
Yes	No	?	
			Mumps
			Tuberculosis (Tine Test)
			Was it positive?

FAMILY HISTORY

How many people are there in your household? _____ Adults _____ Children _____

Who takes care of your child during the day? _____

Do any members of the household or other relatives have a history of:

Check			
Yes	No	?	
			Congenital heart disease
			High blood pressure
			Blood disease
			Severe allergies or asthma
			Mental retardation
			Seizures or convulsions
			Emotional problems
			Cleft lip or palate
			Hepatitis

Check			
Yes	No	?	
			Diabetes
			Urine or kidney problems
			Alcohol abuse
			Sexually transmitted diseases
			AIDS, ARC
			Tuberculosis
			Severe gum disease or decay
			Other diseases (List)

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