COME ORTHODONTICS & PEDIATRIC DENTISTRY

New Patient Medical and Dental History

Child's Name: ______________________________ Date: __________

1. Is your child being treated by a physician at this time? [ ] Yes [ ] No
   If so, what is their name, specialty and phone? ______________________
   When was your child's last medical check-up? ______________________
2. Are all immunizations current? [ ] Yes [ ] No
3. Has your child ever been a patient in a hospital? [ ] Yes [ ] No
4. Has your child ever received general anesthesia? [ ] Yes [ ] No
   If so, what was it for? ______________________
5. Is your child allergic to anything (ex. medications / latex / foods)? [ ] Yes [ ] No
   If so, what? ______________________
6. Is your child taking any medications at this time? [ ] Yes [ ] No
   If yes, what? ______________________
7. Has your child ever been to a dentist before? [ ] Yes [ ] No
8. Has your child ever been prescribed fluoride before? [ ] Yes [ ] No
9. Does your child suck a thumb, finger, or pacifier? [ ] Yes [ ] No
10. Are your child's teeth brushed twice a day? [ ] Yes [ ] No

11. Has your child ever had treatment on or medical consultation for any of the following systems?

[ ] Blood / Circulatory
[ ] Bones
[ ] Endocrine Glands
[ ] Ears
[ ] Eyes
[ ] Gastrointestinal / Stomach
[ ] Kidney / Bladder
[ ] Heart
[ ] Liver
[ ] Lungs
[ ] Muscles
[ ] Nervous System
[ ] Nose
[ ] Skin
[ ] Throat
[ ] Tonsils / Adenoids

[ ] My child has NOT had any treatment or medical consultation for the above systems.

12. Has your child ever been diagnosed as having any of the following conditions?

[ ] Anemia
[ ] Allergy
[ ] Arthritis
[ ] Asthma
[ ] Autism
[ ] Brain Injury
[ ] Behavioral Problems
[ ] Cancer
[ ] Cerebral Palsy
[ ] Cleft Lip / Palate
[ ] Chronic Ear Infections
[ ] Convulsions / Seizures
[ ] Diabetes
[ ] Emotional Disturbance
[ ] Epilepsy
[ ] Eye problems
[ ] Bleeding Problems
[ ] Fainting
[ ] Hearing Loss
[ ] Heart Murmur or Condition
[ ] Hemophilia
[ ] Hepatitis
[ ] HIV / AIDS
[ ] Jaundice
[ ] Learning Disability
[ ] Leukemia
[ ] Nutritional Deficiency
[ ] Orthopedic Problems
[ ] Pneumonia
[ ] Premature Birth
[ ] Respiratory Syncytial Virus
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Sickle Cell Anemia / Trait
[ ] Speech Problems
[ ] Spina Bifida
[ ] Syndrome: ____________
[ ] Tetanus
[ ] Other: ____________

[ ] My child has NOT ever been diagnosed with any of the above conditions

13. What is your reason for bringing your child to the dentist? ______________________

14. Is there anything else that you think we should know about your child? ______________________

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Signature of parent / guardian (or patient if over 18 years of age) Relationship to patient Date