KONDAS dental group

Child's Medical & Dental History

CONFIDENTIAL

Your child's overall health status (past and present medical concerns, medications, etc.) can have an impact on the dental treatment he/she receives. It is very important that each of the following questions be answered completely. Thank you.

Child's Last Name	Child's First Name	Today's Date

Medical History

Physician	Office Phone Number ( )	Date of Last Exam / /

Is your child under medical treatment now? □ Yes □ No

Previous Hospitalizations/Surgeries/Serious Illnesses? □ Yes □ No

If yes, please explain: _____ Date:

_____

_____

Is your child taking any medication(s)? □ Yes □ No

If yes, what medications? _____

_____

_____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications? □ Yes □ No

If yes, please list: _____

_____

_____

Does your child have a history of allergies to any other substances (latex,etc)? □ Yes □ No

If yes, please list: _____

_____

_____

Has your child ever had any of the following:

AIDS or HIV	□ Yes □ No	Hemophilia	□ Yes □ No	Weight Gain	□ Yes □ No
Asthma	□ Yes □ No	Hepatitis/Jaundice	□ Yes □ No	Please explain any other medical Problems your child may have:	
Cancer	□ Yes □ No	Kidney Problems	□ Yes □ No		
Congenital Heart Defect	□ Yes □ No	Liver Problems	□ Yes □ No		
Diabetes	□ Yes □ No	Rheumatic Fever	□ Yes □ No		
Disabilities	□ Yes □ No	Stomach Ulcers	□ Yes □ No		
Epilepsy/Convulsions	□ Yes □ No	Tuberculosis	□ Yes □ No		
Heart Murmur	□ Yes □ No	Weight Loss	□ Yes □ No		

Dental History

Name of Previous Dentist	Location of Previous Dentist	Date of Last Exam / /

Has your child had difficulties with previous dental visits? □ Yes □ No

How often does your child brush?

_____

How often does your child floss?

_____

Does your child:

Clench jaw? □ Yes □ No

Drink from bottle/sippy cup? □ Yes □ No

Suck thumb/finger? □ Yes □ No

Suck/bit lip? □ Yes □ No

Is your child's water fluoridated? □ Yes □ No

Does your child take fluoride supplements? □ Yes □ No

Bite/chew nails? □ Yes □ No

Use a pacifier? □ Yes □ No

Chew hard objects (pencils, etc)? □ Yes □ No

Grind teeth? □ Yes □ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. It is my responsibility to inform the dental office of any changes with my medical status.

Signature of Patient or Parent _____ Date _____

Patient's Initials/Witness/Date	Patient's Initials/Witness/Date	Patient's Initials/Witness/Date	Patient's Initials/Witness/Date