Child Medical and Dental Questionnaire

auroradentalcentre
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Previous Dental Visits and Treatments

1. What is the name of the person filling out this form on behalf of this patient? _____
2. What is your relationship with the patient? _____
3. Is this the first visit to the dentist for this patient? ☐ yes ☐ no
4. Previous Dentist name and phone number _____
5. Date of last complete exam _____
6. Date of last cleaning _____
7. Date of last x-rays _____
8. Have any cavities been noted in the last year? ☐ yes ☐ no ☐ not sure
9. Has this patient ever received local anesthetic (freezing)? ☐ yes ☐ no ☐ not sure
10. Has this patient ever had protective sealants placed? ☐ yes ☐ no ☐ not sure
11. Has this patient had any teeth, baby or permanent extracted? ☐ yes ☐ no ☐ not sure
12. Has it been suggested that space required maintaining with or without the use of an appliance, explain? _____ ☐ yes ☐ no ☐ not sure
13. Has this patient ever had any injuries to their teeth or jaw? ☐ yes ☐ no ☐ not sure
14. Is this patient currently being treated by an orthodontist? ☐ yes ☐ no ☐ not sure
15. Has anyone in this patient's family had orthodontics? ☐ yes ☐ no ☐ not sure

Today's Visit

16. What brings you into the office today? _____
17. Is this patient in any discomfort? ☐ yes ☐ no
18. Does this patient believe there is anything wrong with their teeth? ☐ yes ☐ no ☐ not sure

Current Conditions

19. When does the patient brush their teeth? ☐ morning ☐ right after meals ☐ after eating ☐ before bed
20. Does this patient snack between meals? ☐ yes ☐ no ☐ not sure
21. Does this patient eat sweets such as candy, pop or gum? ☐ yes ☐ no ☐ not sure
22. Does your child receive fluoride?
    - ☐ community water supply
    - ☐ community health programs
    - ☐ home dispensed drops
    - ☐ dental visits
    - ☐ none

Medical History

23. What is this patient's medical Doctor's name? _____
24. Is this patient currently taking any medication? ☐ yes ☐ no ☐ not sure
    If yes, please list ALL medications _____
25. What is this patient's medical Doctor's phone number _____
26. Date of last complete physical examination? _____
27. Is this patient currently under a physician's care? ☐ yes ☐ no ☐ not sure

Medications-Reactions or Allergies

28. Has this patient ever had an adverse reaction to Latex? ☐ yes ☐ no ☐ not sure

29.Has this patient ever had an adverse reaction to any Metal? ☐ yes ☐ no ☐ not sure
30.Has this patient ever had an adverse reaction to Aspirin? ☐ yes ☐ no ☐ not sure
31.Has this patient ever had an adverse reaction to any medications? ☐ yes ☐ no ☐ not sure
32.Has this patient ever had an adverse reaction to Codeine? ☐ yes ☐ no ☐ not sure
33.Has this patient ever had an adverse reaction to Penicillin? ☐ yes ☐ no ☐ not sure
34.Has this patient ever had an adverse reaction to Sulfa Drugs? ☐ yes ☐ no ☐ not sure
35.Has this patient ever had an adverse reaction to Local Anesthetic(freezing)? ☐ yes ☐ no ☐ not sure
36.Has this patient ever had an adverse reaction to Nitrous Oxide? ☐ yes ☐ no ☐ not sure
37.Has this patient ever had an adverse reaction to any other drugs? ☐ yes ☐ no ☐ not sure
38.Has this patient ever been treated for or told they have Arthritis? ☐ yes ☐ no ☐ not sure
39.Has this patient ever been treated for or told they have Asthma? ☐ yes ☐ no ☐ not sure
40.Has this patient ever been treated for or told they have a Blood Disorder such as Anemia or Leukemia? ☐ yes ☐ no ☐ not sure
41.Has this patient ever been treated for or told they have Cancer? ☐ yes ☐ no ☐ not sure
42.Has this patient ever been treated for or told they have Diabetes? ☐ yes ☐ no ☐ not sure
43.Has this patient ever been treated for or told they have Epilepsy? ☐ yes ☐ no ☐ not sure
44.Has this patient ever experienced heavy bleeding? ☐ yes ☐ no ☐ not sure
45.Has this patient ever been treated for or told they have a Heart Murmur? ☐ yes ☐ no ☐ not sure
46.Has this patient ever been treated for or told they have Hepatitis B? ☐ yes ☐ no ☐ not sure
47.Has this patient ever been treated for or told they have HIV(AIDS)? ☐ yes ☐ no ☐ not sure
48.Has this patient ever had any Joint Replacement? ☐ yes ☐ no ☐ not sure
49.Has this patient ever been treated for or told they have Liver Disease? ☐ yes ☐ no ☐ not sure
50.Has this patient ever been treated for or told they have a Mental Disability(by a doctor)? ☐ yes ☐ no ☐ not sure
51.Has this patient ever been treated for or told they have Renal Disease? ☐ yes ☐ no ☐ not sure
52.Has this patient ever been treated for or told that have Rheumatic Fever? ☐ yes ☐ no ☐ not sure
53.Has this patient ever been treated for or told they have Thyroid Disorder? ☐ yes ☐ no ☐ not sure
54.Has this patient ever been treated for or told they have Tuberculosis? ☐ yes ☐ no ☐ not sure
55. Is there anything else we should know? ☐ yes ☐ no ☐ not sure

_____
_____
_____

I HEREBY CERTIFY THAT I HAVE FILLED OUT THIS FORM ON BEHALF OF THIS PATIENT AND HAVE NOT KNOWINGLY OMITTED ANY IMPORTANT INFORMATION REGARDING THEIR HEALTH WHICH MAY EFFECT THEIR SAFETY AND THE SAFETY OF THE DOCTOR AND STAFF

PATIENT NAME: _____

PARENT/GUARDIAN: NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

DOCTOR'S SIGNATURE: _____