

**DENTAL HISTORY OF CHILD OR TEENAGER**

Patient Name \_\_\_\_\_ (Nickname) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Is this an emergency visit: Yes \_\_\_ No \_\_\_ Is this the first visit to a dentist: Yes \_\_\_ No \_\_\_ Male \_\_\_ Female \_\_\_  
 Name of former dentist \_\_\_\_\_ City \_\_\_\_\_  
 Has any member of your family been a patient of this office or our other office before: Yes \_\_\_ No \_\_\_  
 Name(s) \_\_\_\_\_  
 Present dental problem as you see it (if any) \_\_\_\_\_  
 Has your child had any past bad dental experiences? Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_  
 \_\_\_\_\_  
 Who may we thank for referring you to our office? \_\_\_\_\_  
 Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL HISTORY OF CHILD OR TEENAGER**

*In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.*

1. Is your child in good health ..... YES NO
2. Has there been any change in child's general health within the past year..... YES NO
3. The last physical examination was on \_\_\_\_\_
4. Is child now under the care of a physician? ..... YES NO  
 If so, what is the condition being treated? \_\_\_\_\_
5. The name and address of physician is \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_
6. Has child had any serious illness or operation? ..... YES NO  
 If so, what was the illness or operation? \_\_\_\_\_
7. Has child been hospitalized or had a serious illness within the past five (5) years ..... YES NO  
 If so, what was the problem? \_\_\_\_\_
8. Is your child allergic to latex? ..... YES NO
9. Has child had any of the following diseases or problems?
  - a. Rheumatic fever or rheumatic heart disease..... YES NO
  - b. Congenital heart lesions..... YES NO
  - c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure)..... YES NO
    - 1) Heart murmur ..... YES NO
    - 2) Does child have pain in chest upon exertion..... YES NO
    - 3) Is child ever short of breath after mild exercise..... YES NO
  - d. Allergy..... YES NO
  - e. Sinus trouble..... YES NO
  - f. Asthma or hay fever ..... YES NO
  - g. Hives or a skin rash ..... YES NO
  - h. Fainting spells or seizures ..... YES NO
  - i. Diabetes ..... YES NO
    - 1) Does child have to urinate (pass water) more than six times a day ..... YES NO
    - 2) Is child thirsty much of the time ..... YES NO
    - 3) Does your child's mouth frequently become dry..... YES NO
  - j. Hepatitis, jaundice or liver disease..... YES NO
  - k. Arthritis ..... YES NO
  - l. Inflammatory rheumatism (painful swollen joints) ..... YES NO
  - m. Stomach ulcers..... YES NO
  - n. Kidney trouble ..... YES NO
  - o. Tuberculosis..... YES NO
  - p. Is there a persistent cough or coughing up of blood ..... YES NO
  - q. Low blood pressure..... YES NO
  - r. Venereal disease..... YES NO
  - s. Auto Immune Disease ..... YES NO
  - t. Other..... YES NO
10. Has child had abnormal bleeding associated with previous extractions, surgery or trauma..... YES NO
  - a. Does your child bruise easily..... YES NO
  - b. Has child ever required a blood transfusion..... YES NO
 If so, explain the circumstances \_\_\_\_\_  
 \_\_\_\_\_

- |  |     |    |
|--|-----|----|
| 11. Is there any blood disorder such as anemia .....                                       | YES | NO |
| 12. Has child had surgery or x-ray treatment for a tumor, growth, or other condition ..... | YES | NO |
| 13. Is child taking any drug or medicines .....  | YES | NO |
| If so, what _____  |     |    |
| 14. Has your child taken the diet drug Phen-Fen? .....                                     | YES | NO |
| 15. Are any of the following drugs routinely used?   |     |    |
| a. Antibiotics or sulfa drugs .....  | YES | NO |
| b. Anticoagulants (blood thinners) .....   | YES | NO |
| c. Medicine for high blood pressure .....  | YES | NO |
| d. Cortisone (steroids) .....  | YES | NO |
| e. Tranquilizers .....   | YES | NO |
| f. Antihistamines .....  | YES | NO |
| g. Aspirin .....   | YES | NO |
| h. Insulin, tolbutamide (Orinase) or similar drug .....                                    | YES | NO |
| i. Digitalis or drugs for heart trouble .....  | YES | NO |
| j. Nitroglycerin .....   | YES | NO |
| k. Ritalin .....   | YES | NO |
| l. Other .....   | YES | NO |
| 16. Is there a history of allergic reaction in your child (or immediate family) to:        |     |    |
| a. Local anesthetics .....   | YES | NO |
| b. Penicillin or other antibiotics .....   | YES | NO |
| c. Sulfa drugs .....   | YES | NO |
| d. Barbiturates, sedatives, or sleeping pills .....  | YES | NO |
| e. Aspirin .....   | YES | NO |
| f. Iodine .....  | YES | NO |
| g. Codeine or other narcotics .....  | YES | NO |
| h. Other .....   | YES | NO |
| 17. Does child have any medical condition not listed above.....                            | YES | NO |
| If so, explain _____   |     |    |
| 18. Does child have a special problem.....   | YES | NO |
| Explain _____  |     |    |

I, consent to have Drs. Chiang, Morris, Murillo, Saisho, Hamilton, their Associates and Staff perform diagnostic dental procedures including X-Rays, teeth cleaning, oral examination, and application of flouride on teeth. I understand that before any further care is rendered, I will be so informed and consent obtained.

\_\_\_\_\_  
Signature of Parent or Legal Guardian      \_\_\_\_\_  
Parent or Legal Guardian Printed Name      Date \_\_\_\_\_

**FOR DENTISTS ONLY**

**PATIENT RESUME:**

**HOSPITALIZATIONS:**

**SURGERIES:**

**MEDICATIONS:**

**ALLERGIES:**

**MEDICAL ALERT:**

**A.S.A. I, II, III, IV       MEDICAL CONSULT REQUESTED**

\_\_\_\_\_  
**Signature of Dentist**      Date \_\_\_\_\_