

## Child's Medical and Dental

CHILD'S DENTAL HI	STOBY							
Reason for today's visit:		Emergency	Consultation					
	Yes How Long?	2 82 29						
	following problems with a	a check mark:						
Discomfort, clicking, or pop	oping in jaw Lost/Broken fill	lings Stained Teeth F	Red, swollen, or bleeding gums.					
Teeth grinding Locking jaw Sensitive tooth, teeth, or gums Ringing in ears Bad breath								
Blisters/Sores in or around mouth Broken/Chipped tooth Loose tooth								
Other(s):								
	otics prior to cleanings? Y	es No Don't know	V					
Is child considered to be a	a nervous patient? Yes	No						
Previous Dentist:								
	Jame , , , , , , , , , , , , , , , , , , ,	<b>T</b> T (	Phone#					
Last Dental exam:/	/ Last Dental		<u>/</u>					
Times a day child brushes		a week child flosses?						
Does child use an electric			bristle toothbrush? Yes No					
How would you rate the c	child's smile? (worst) 1	2 3 4 5	6 7 8 9 10 (best)					
CHILD'S MEDICAL F	ISTORY							
Is child taking any of the	e following meds? Pain k	killers (including aspirin, o	etc.) Ritalin Stimulants					
	lizers Insulin Muscle rela							
Do you have or have you h	ad any of the following dise	eases, medical condition	ons or procedures?					
	Y N Organ Problems	Y N Tonsillitis	-					
Y N Rheumatic Fever	Y N Kidney Problems	Y N Asthma						
Y N Artificial Heart Valves	Y N Liver Problems	Y N Hepatitis						
Y N Congenital Heart Defect		Y N HIV+/AIDS/ARC						
<b>Y N</b> Scarlet Fever	Y N Cleft Lip/Palate	Y N Difficulty Breathin	ıg					
Y N Surgeries/Operations	Y N Artificial Bones/Joints	Y N Diabetes/ Hypogl	ycemia					
Y N Cancer/ Tumors	Y N Psychiatric Problems	Y N Birth Defects						
<b>Y N</b> Chemotherapy	Y N Cerebral Palsy	Y N Fainting/ Seizures						
	Y N High/Low Blood Pressure							
<b>Y N</b> Hearing Problems	Y N Tuberculosis TB	Y N Bleeding Problem	S					
Y N Hyper Active/ADD	Y N Hemophilia	Y N Blood Transfusion	rs					
Please list any other surge	eries or medical conditions	you have or ever had	l:					
Is Child allergic to: Late		2	Aspirin Codeine					
	ods:	Others:						
Please rate the child's ger	ieral health from 1 - 10:		wear contact lenses? Yes No					
Have you ever taken the o		How Long?	Child's Blood type:					
Does this child do any of	the following? Thumb/Fin		Thrusting/Sucking					
Heavy Snoring Mout	h Breathing Lip Sucking	g/Biting						
Signature			Date/					
By signing above, I ackno	wledge that the above is true and	d correct to the best of my	knowledge. (parent or guardian)					