Eric S. Yao, DDS, MAGD

Dedicated Dental Care for Your Family's Good Health

CHILD DENTAL HISTORY

Patient Name _____ ☐ Male ☐ Female Birthday_____

What would you like us to do for your child today? _____

Is your child taking any form of fluoride? ____Tablets ____Drops ____Rinse ____Gel

Does your child have oral habits? ____Thumb or finger sucking ____Nail or lip biting ____Pacifier

____Nursing Bottle Others_____

Has your child been to a dental office previously? YES NO Was it a positive experience? YES NO

If not, explain _____

Former Dentist _____ Date of last visit _____ Date of last X-Rays _____

Has your child received any injuries to the mouth or teeth? YES NO If yes, describe _____

Has your child complained of tooth discomfort? YES NO If yes, describe _____

Has your child ever experienced a mouth, chin, or jaw joint injury? YES NO If yes, describe _____

_____

Does your child have speech problems? YES NO If yes, describe _____

CHILD MEDICAL HISTORY

Because conditions of the mouth can be hereditary, it is helpful to know if your child is adopted. YES NO

Child's Physician_____ Phone _____ Date of last visit _____

What was the nature of the visit? _____

Has your child ever been hospitalized? YES NO If yes, explain _____

Please describe any medical treatment including injuries, blood transfusions, pending surgery, special needs, or any other medical information we should be aware of that has not yet been discussed. _____

_____

Does your child have any drug allergies? YES NO If yes, describe _____

Is your child taking any medications? YES NO If yes, for what condition _____

Please indicate if your child has had any of the following:

____ADD/ADHD	____Ear Infection	____HIV	____Spina Bifida
____Asthma	____Epilepsy	____Kidney Condition	____Thyroid Disease
____Anemia	____Fainting or Seizure	____Latex Sensitivity	____Tonsillitis
____Cancer	____Food Allergies	____Liver Condition	____Tuberculosis
____Cerebral Palsy	____Headaches	____Respiratory Condition	____Other _____
____Chicken Pox	____Hearing Impaired	____Rheumatic Fever	_____
____Cough	____Heart Condition	____Shortness of Breath	_____
____Diabetes	____Hemophilia	____Sinus Problems	_____
____Disorders of the Blood	____Hepatitis	____Skin Rash	_____

_____

Patient / Guardian's Name **Signature** **Date**