Just Smiles
FAMILY AND COSMETIC DENTISTRY

CHILD MEDICAL HISTORY FORM

Child's name _____ **Preferred name:** _____ **Age:** _____

Date of Birth ____/____ /____ **Last dental visit** _____ **Purpose of that visit?** _____ **Grade:** _____

Has your child ever had any serious or difficult problems associated with previous dental treatment? ☐ **Yes** ☐ **No**
If yes, please explain: _____

_____

Child's Physician: _____ **Phone #:** _____

Is your child allergic to any of the following? ☐ **Penicillin** ☐ **Codeine** ☐ **Aspirin** ☐ **Latex** ☐ **Anesthetic**
☐ **My child has no known allergies**

Is your child taking any prescription or non-prescription medication at the present time? ☐ **YES** ☐ **NO**

If yes, please list names and reason: _____

_____

Does your child have or ever had any of the following medical problems? (if yes, please explain)

☐ **Abnormal bleeding**
☐ **Handicaps/Disabilities**
☐ **ADD/ADHD**
☐ **Any hearing problems**
☐ **Hospitalization**
☐ **Heart Murmur**
☐ **Any surgery**
☐ **Hemophilia**
☐ **HIV**
☐ **Joint replacement**
☐ **Artificial heart valve**
☐ **Hepatitis A,B,C**
☐ **Asthma**
☐ **Kidney/Liver Disease**
☐ **Cancer**
☐ **Rheumatic Fever**
☐ **Heart Disease**
☐ **Sickle cell disease**
☐ **Convulsions/Epilepsy**
☐ **Tuberculosis**
☐ **Diabetes**
☐ **Sinus Problems**
☐ **Allergies**
☐ **Tonsils removed**
☐ **Adenoids removed**
☐ **Radiation treatment**
☐ **Pacemaker**
☐ **High Blood Pressure**
Other_____
_____
_____

Does your child drink fluoridated water? ☐ **Yes** ☐ **No**
Does your child take fluoride supplements? ☐ **Yes** ☐ **No**
Does your child brush his/her teeth daily? ☐ **Yes** ☐ **No**
When? ☐ **Morning** ☐ **Evening** **Do you help with brushing?** ☐ **Yes** ☐ **No**
Does your child regularly drinks the following? ☐ **Milk** ☐ **Chocolate Milk** ☐ **Juice** ☐ **Soda** ☐ **Gatorade**

Does your child have any of the following habits? ☐ **Lip sucking / biting**
☐ **Nursing bottle habits**
☐ **Thumb / finger sucking**

I understand that the information that I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my child's medical history. I authorize Just Smiles to perform the necessary dental services my child will need.

_____ _____
Parent Signature ***Date***

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