Irmo Kids Dental Medical History

Child's Name:______________________________________ Day Time Phone:_________________________
Date of Birth:_______________________ Sex: ___M ___F Siblings seen here:_________________________
Home Address: _____________________________ City: __________________ State: _____ Zip: _____________
Email Address: ____
Child's Physician: ________________________________ Phone #: ___________________________________
Physician Address: ____
Is the child currently being treated for any condition? __Y __N Please explain: ______________________________

Does your child have any allergies to the following?
Pollen Latex Dust Food Food Dye Other: Please explain
____

List all medication the child is currently taking: ____
List any medication(s) that cause the child allergic reactions: _____________________________________

Please check any that pertain to your child

Abnormal Bleeding
Aids/HIV*
Anemia
Attention Deficit Disorder/ADHD
Asthma
Autism
Any hospital stay/surgery
ANY HEART CONDITION *
Blood Transfusion*
Cancer
Cerebral Disorders
Chicken Pox
Convulsions
Diabetes
Seizure Disorder/Epilepsy*
Hearing Impairment
Hemophilia*
Hepatitis (A, B or C)*
High Blood Pressure
Hives
Kidney Problems
Liver Problems
Low Blood Pressure
Lupus
Measles
Mitral Valve Prolapse*
Mononucleosis
Rheumatic Fever
Scarlet Fever
Sickle Cell Anemia*
Skin Rash
Tonsillitis
Tuberculosis*
Excessive Gagging
Fainting or Dizziness
Prosthetic Joints*
Sickle Cell Trait

*** Indicates we will need medical clearance from doctor's office or pre-medication is required before appointment.**

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information that has not been covered above:
____
____

Dental History

What is the primary reason for today's visit? ____
Is the child currently in pain: __Y __N Has the child ever had any pain/tenderness in his/her jaw joint? __Y __N
Has the child ever had any injuries to his/her teeth, mouth, head or jaw? __Y __N If yes, describe: ________________________
Has the child ever experienced problems with previous dental work? _Y _N If yes, explain: ____________________________
Is the child's water fluoridated? __Y __N
Is the child taking fluoridated supplements? __Y __N
Brush his/her teeth daily? __Y __N
Does an adult assist with brushing? __Y __N
Floss his/her teeth daily? __Y __N
Does an adult assist with flossing? __Y __N

Does/did the child have any of the following habits?

Y N Lips sucking/biting
Y N Nail biting
Y N Mouth Breather
Y N Clenching/grinding teeth
Y N Used pacifier until age ___
Y N Nursing bottle habits until age ___
Y N Thumb/finger sucking until age ___
Y N Tongue/cheek biting
Y N Tongue thrust

*I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform necessary dental services my child may need.

Signature ____ Date ______________________________