Child's Examination Form

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____ DATE OF EXAM _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ CELL PHONE _____

PARENT OR GUARDIAN'S NAME _____ HOME PHONE _____ BUSINESS PHONE _____

MEDICAL HEALTH HISTORY

General Health (please check):
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who is child's physician?
Address?

When did child have last complete physical examination?

Is child being treated for anything now?

Did child ever have (Please check):

☐ Kidney Disease	☐ High Cholesterol	
☐ Diabetes	☐ Tuberculosis	☐ Epilepsy / Convulsions
☐ Rheumatic Fever	☐ Anemia	☐ Speech Impediment
☐ Hepatitis	☐ Asthma	☐ Hearing Problem
☐ Liver Disease	☐ Heart Trouble / Murmur	☐ HIV Positive – AIDS
☐ Other:	☐ ADHD/ADD	☐ Autism

Is child allergic to (please check):
☐ Penicillin ☐ Codeine ☐ Novocaine ☐ Latex ☐ Other

Is child taking any medications now?
If so, what?

Does child have any allergies?

Is child subject to prolonged bleeding?

Does child have any emotional problems?

I VERIFY THE ABOVE AND GIVE MY CONSENT FOR TREATMENT

_____
Parent or Guardian's Signature

P L E A S E A N S W E R

DENTAL HEALTH HISTORY – CHILD

Date of last dental examination:

What concerns you most about your child's dental health?

Does your child ever have dental pain? If so, when?

Did child ever have a negative dental experience?
Discuss

Mouth habits: ☐ Thumb sucking ☐ Mouth breathing ☐ Bottle nursing

Has the child had teeth removed?

Has child had orthodontic treatment?

Does your child have a "sweet" tooth?

How often does your child brush?
Floss?

Has child received any flouride treatment?
☐ pill / vitamins ☐ topical ☐ water

Are you happy with the appearance of child's teeth?

Has anyone explained the importance of primary teeth?

A L L Q U E S T I O N S

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