**Lakewood Dental Group**

## Child Dental History

Patients Name:_____ Date: _____

Childs last dental visit: _____ For what: _____

Childs attitude towards dentistry: _____

Any injuries to the mouth, teeth, or head? _____

Any Brushing/ Flossing Habits? _____

Any dental problems that the child has complained about?: _____

Anything about the child's teeth, mouth/ smile that you are concerned about? Yes/ No

If yes, Please explain: _____

Is the child in Orthodontics? Yes/ No If Yes: When was it started: _____

Has there been Orthodontic Treatment in the past? Yes/ No

If Yes, When was completion: _____

Are there Orthodontic problems you are aware of and concerned about?

If Yes, Explain:_____

Childs Physician: _____ Phone Number: _____

Last Physical Exam: _____ Results: _____

Is child under physician care now? Yes/ No Explain: _____

Has child been hospitalized? Yes/ No Explain: _____

Has child has surgery? Yes/ No Explain: _____

Please list all drugs child is currently taking: _____

Any drug allergies? Yes/ No Please List: _____

**Has your child has any history/problems with any of the following? Please circle Yes or No**

| | | |
|---|---|---|
| **AIDS/ HIV:** Yes/ No | **Diabetes:** Yes/ No | **Intellectual Problems:** Yes/ No |
| **Asthma:** Yes/ No | **Emotional Problems:** Yes/ No | **Malignancies:** Yes/ No |
| **ADD:** Yes/ No | **Epilepsy:** Yes/ No | **Mitral valve prolapse:** Yes/ No |
| **ADHD:** Yes/ No | **Fainting:** Yes/ No | **Physical Problems:** Yes/ No |
| **Behavioral Problems:** Yes/ No | **Hearing:** Yes/ No | **Tuberculosis:** Yes/ No |
| **Congenital Heart Disease:** Yes/ No | **Hemophilia:** Yes/ No | **Rheumatic Heart Defects:** Yes/ No |
| **Convulsions:** Yes/ No | **Heart Problems:** Yes/ No | **Other: _____** |
| **Cognitively Impaired:** Yes/ No | **Heart Murmur:** Yes/ No | |

Has child had any problems/ History not listed about? If Yes- Please explain:

_____

**Signature Of Parent/Guardian: _____ Date: _____**