

MEDICAL/DENTAL HISTORY

Physician's Name: _____ Physician's Phone Number: _____

- Yes No Is your child in good health?
Date of last physical examination: _____
- Yes No Has your child had surgery/hospitalizations? Please give reason and date _____

- Yes No Is your child taking any medications? Please give medication and reason _____

- Yes No Is your child allergic to any medications? _____
- Yes No Is your child allergic to anything (latex, milk, grass, etc....)? _____
- Yes No Are your child's immunizations up to date?

Please check if your child has or has had any of the following:

Cardiovascular

- High Blood Pressure
 Heart Murmur
 Mitral Valve Prolapse
 Rheumatic Fever
 Other Heart Problem

Pulmonary

- Asthma
 Seasonal Allergies
 Tuberculosis

Hematologic

- Blood Transfusion
 Anemia
 HIV/AIDS
 Hemophilia
 Leukemia
 Sickle Cell Anemia
 Other Blood Disorder

Neurologic

- Vision Problems
 Hearing Loss
 Epilepsy/Seizures
 Severe Headaches
 Fainting
 Cerebral Palsy

Endocrine

- Diabetes
 Thyroid Disease
 Taking Steroids or Cortisone

Genitourinary

- Kidney Transplant
 Urinate Frequently
 Other Kidney/Bladder Problem

Dermal/

Musculoskeletal

- Latex Allergy
 Skin Rash
 Rheumatoid Arthritis

Gastrointestinal

- Hepatitis
 Liver Disease

Other Conditions

- Frequent Sore Throat
 Tobacco Use
 Cleft Lip/Palate
 Radiation Therapy
 Chemotherapy
 Condition/Problem Not Listed

Syndrome: _____

If you checked any of the above, please explain _____

Is today your child's first dental visit? Yes No
Name of previous dentist: _____ Date of last visit/x-rays: _____

Has your child had any unfavorable dental experiences? Yes No Explain _____

Has your child every had injury to his/her face or mouth? Yes No If so, when and how? _____

How often does your child brush his/her teeth? _____ Floss? _____ Does someone help? Yes No

Does your child use a fluoridated toothpaste? Yes No Is your home water supply fluoridated? Yes No

Do you give your child any other form of fluoride? Yes No What? _____

Does your child drink milk/soda/juice between meals? Yes No

Does your child eat frequent snacks between meals? Yes No

Are there any mouth habits?

Bottle/Breastfeeding **Pacifier** **Sippy Cup** **Finger/Thumb Sucking** **Tooth Grinding** **Tongue Thrust**
Mouth Breathing

Do you expect your child to cooperate for the exam? Yes No

I hereby acknowledge that the information provided above is a true representation of my child's medical and dental history/condition.

Parent's/Guardian's Signature: _____ **Date:** _____

Rodney A. Jackson, D.M.D. • Morgan C. Dillow, D.M.D. • R. Michael Day, D.M.D.
2517 Sir Barton Way, Suite 200 • Lexington, KY 40509 • (859) 543-2456