



Renée L. Goodspeed, D.D.S. Raymond D. Laurion, D.D.S. Puneet Kochhar, D.M.D.
40 Winter Street, Suite 201, Rochester, NH 03867

CHILD DENTAL MEDICAL HISTORY

Patient's Name _____
Last First I Date of Birth
Parent's Name _____

CIRCLE THE APPROPRIATE ANSWER

DENTAL HISTORY

- | | | | |
|-----|--|-----|----|
| 1. | Is this the child's first visit to a dentist?..... | YES | NO |
| | If not, how long since the last visit to the dentist? _____ | | |
| 2. | When was the last time the teeth were cleaned? _____ | | |
| 3. | Does child eat between meals? | YES | NO |
| 4. | Does child eat sweets (candy, soda, gum)? | YES | NO |
| 5. | Does child eat well balanced meals? | YES | NO |
| 6. | Does child brush teeth upon rising?..... | YES | NO |
| | When going to bed? | YES | NO |
| | After eating any food? | YES | NO |
| 7. | Do you live in an area with flouridated water? | YES | NO |
| 8. | Have teeth been treated with flourides? | YES | NO |
| 9. | Have cavities been noted in the past? | YES | NO |
| 10. | Were any teeth removed by extraction? | YES | NO |
| 11. | Was it suggested that space be maintained? | YES | NO |
| 12. | Was appliance placed? | YES | NO |
| 13. | Have there been any injuries to teeth (chips, blows, fall, etc)? If so, describe _____ | YES | NO |
| 14. | Has child had any unfavorable dental experience? | YES | NO |
| 15. | How many children in your family? _____ | | |
| 16. | Has anyone in the family had orthodontics? | YES | NO |
| 17. | Has child ever received a local anesthetic or any form of anesthetic? | YES | NO |
| 18. | Has child ever had occlusal sealants? | YES | NO |

MEDICAL HISTORY

- | | | | |
|-----|---|-----|----|
| 1. | Is child in good health? | YES | NO |
| 2. | Is child under care of physician? If yes, since when? _____ Why? _____ | YES | NO |
| 3. | Name of Physician _____ | | |
| 4. | Is child receiving any medication? When? _____ Why? _____ | YES | NO |
| 5. | Has the child had any serious illness? When? _____ Why? _____ | YES | NO |
| 6. | Is child allergic to penicillin, antibiotics or other drugs? | YES | NO |
| 7. | Does the child have any other allergies? | YES | NO |
| 8. | Has child had surgery? | YES | NO |
| 9. | Is surgery contemplated? | YES | NO |
| 10. | Is child subject to profuse bleeding? | YES | NO |
| 11. | Is child subject to nervous disorders? | YES | NO |
| 12. | Fainting? | YES | NO |
| 13. | Dizziness? | YES | NO |
| 14. | Has child had history of: diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection? | YES | NO |



I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Parent's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____