Westbrook Dental Centre
Child - Medical History

Please complete the following medical and dental questions as accurately as possible.
This is essential in order for the dentist to provide safe and optimal dental care.

Patient Name : ______ MEDICAL ALERT : ______

Date : ______

1. When did your child last visit the physician? ______

   Reason : ______

2. Has your child ever had any serious illness or been in the hospital? ☐ Yes ☐ No

   Specify : ______

3. Does your child have any known medical, physical or mental handicaps? ☐ Yes ☐ No

   Specify : ______

4. Has your child ever had any of the following:

☐ Measles	☐ Asthma	☐ Shortness of breath	☐ Kidney Disease
☐ Mumps	☐ Hay Fever	☐ Lung Disease	☐ Diabetes
☐ Chicken Pox	☐ Heart Trouble	☐ Tuberculosis	☐ Gland Trouble
☐ Scarlet Fever	☐ Rheumatic Fever	☐ Nervous Disorder	☐ Broken Bones
☐ Strep. Throat	☐ Chest Pains	☐ Epilepsy	☐ Operations
☐ Tonsilectomy	☐ Fainting Spells	☐ Liver Disease	☐ Ear Trouble
☐ Adenoid Trouble	☐ Ankle Swelling	☐ Jaundice	☐ HIV Positive
☐ Abnormal Blood Pressure	☐ AIDS	☐ Other ______	

   If "Yes" to any of the above, please specify: ______

5. Has your child ever had any of the following:

☐ Penicillin	☐ Other Antibiotics	☐ Cortisone
☐ Local Anaesthesia	☐ General Anaesthesia	

6. Is your child taking any medication now? ☐ Yes ☐ No

   Drug : ______ Reason : ______

   Drug : ______ Reason : ______

7. Has your child ever had a negative reaction to any drug? ☐ Yes ☐ No

   Specify : ______

8. Is your child allergic to anything? ☐ Yes ☐ No

   Specify : ______

9. Has your child ever has rheumatic fever? ☐ Yes ☐ No

10. Have you ever been advised that your child needs to take antibiotics before dental treatment? ☐ Yes ☐ No

☐ Yes ☐ No

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(Continued)

12. Does your child have any blood disease? .... ☐ Yes ☐ No

Specify :

13. Does your child have any emotional problems? .... ☐ Yes ☐ No

12. Is there a history of any inherited diseases in the family? .... ☐ Yes ☐ No

Specify :

Westbrook Dental Centre
Children's Dental History

1. Has your child has previous dental care? ☐ Yes ☐ No
   When?:
2. Has she or he ever has an unpleasant experience associated with dental treatment? ☐ Yes ☐ No
   Specify:
3. Has your child ever had an accident or surgery about the mouth? ☐ Yes ☐ No
   Specify:
4. Is there a family history of any of the following? ☐ Yes ☐ No
   - ☐ High decay rate
   - ☐ Missing teeth
   - ☐ Spaced teeth
   - ☐ Tooth deformity
   - ☐ Extra teeth
   - ☐ Gum disease
   - ☐ Crooked or crowded teeth

   If "Yes" to any of the above, please specify:
5. Is there a family history of any of the following? ☐ Yes ☐ No
   - ☐ Thumbsucking
   - ☐ Nail biting
   - ☐ Lip biting
   - ☐ Mouth breathing
   - ☐ Tongue thrusting
   - ☐ Fingersucking
   - ☐ Teeth grinding

   If "Yes" to any of the above, please specify:
6. How often does your child brush his or her teeth?
7. Do you supervise your child while they are tooth brushing? ☐ Yes ☐ No
8. Has your child ever recieved oral hygiene or toothbrushing instruction from a dentist or dental hygienist? ☐ Yes ☐ No
9. Has your child ever recieved fluoride supplements in the diet or water supply? ☐ Yes ☐ No
10. Were his or her teeth ever treated with decay preventing topical fluorides? ☐ Yes ☐ No
11. Are you interested in a caries (dental decay) preventive program for this child? ☐ Yes ☐ No

I authorize Westbrook Dental Centre to contact me in regards to dental treatment.

I certify that the above medical and dental information is true for the child and complete to the best of my knowledge.
I authorize the dentist to contact my child's physician if required.

Child's Name:

Parent/Guardian Signature:

Date: