

## Youth Dental & Medical History Form

Patient Name:      
Last First MI Preferred Name

Birth Date:

Please check one:

- First Dental Visit-if this is patient's first dental visit, please skip to Dental Care section.
- Transferred from another dental office or are updating medical history information for existing patient.

### Previous Dentist

Previous Dentist's Name, Address, City, State, Zipcode, Telephone:

Date of last dental visit:

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### Dental Care

Frequency of dental care:

- Regular (every 3-6 months)
- Infrequent (every 12 months)
- Periodic (every 7-12 month)
- Emergency (for pain/problem management)

Please describe patient's daily oral health routine (including whether they are independent, receiving assistance, etc.):

Please describe any dental concerns:

Does the patient take fluoride in any form, including flouridated water? Please explain briefly:

## Youth Dental & Medical History (Continued)

Please check all that apply:

- Patient has complained of dental problems or pain
- Patient has had an upsetting dental experience
- Patient seems nervous about receiving dental treatment
- Patient has experienced an injury to the mouth or head
- Patient has mouth habits (thumbsucking, nail-biting, mouth breathing, bottle, etc.)
- Patient has current health problems
- Patient is currently taking medications
- Patient is allergic to a medication or substance
- Patient has had allergic skin reaction to metal jewelry
- Patient has had an overnight hospital stay in the past 5 years
- Patient has been told they need premedication prior to dental treatment

Please explain any checked boxes above:

## Physician Information

Date of last physical examination, Physician's Name, Address, City, State, Zipcode, Telephone:

Please indicate any condition which patient has had or is currently experiencing (check all that apply):

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> A.I.D.S./H.I.V.    | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> Anemia         |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Measels          | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Epilepsy       |
| <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Mumps          |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Heart Problems     | <input type="checkbox"/> Sinus Problems   | <input type="checkbox"/> Chicken Pox     | <input type="checkbox"/> Hepatitis      |
| <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Convulsions      | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Tuberculosis   |

Please explain any checked boxes above:

Response Date: