Name ____Date of Birth____________

Physician's Name ____ Phone: ________________

Is your child under the care of a physician? ☐ Yes ☐ No

If yes, please explain: ____

When was your child's last complete physical exam? _____________________________________

Has your child ever had any of the following? Please check those that apply:

☐ AIDS	☐ Epilepsy	☐ Hepatitis	☐ Seizure Disorder
☐ Asthma	☐ Excessive Bleeding	☐ HIV Positive	☐ Speech Impairment
☐ Behavior Problems	☐ Eyesight Problems	☐ Infections	☐ Penicillin Allergy
☐ Birth Defects	☐ Fainting	☐ Kidney Infections	☐ Latex Allergy
☐ Cancer	☐ Frequent Headaches	☐ Liver Problems	OTHER:
☐ Cerebral Palsy	☐ Hearing Loss	☐ Mental Retardation	☐ ____________
☐ Diabetes	☐ Heart Murmur	☐ Nervous Disorders	☐ ____________
☐ Dizziness	☐ Heart Trouble	☐ Rheumatic Fever	☐ ____________

Does your child have any allergies? Please List: ____

Does your child have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: ____

Please list any medications and health products your child is taking :

____

Does your child have any problems with antibiotics or anesthetics? ___________________________

Is your child sensitive to metals or latex? ____

Is this you child's first visit to the dentist? ____

If not, when was the last visit? ____________________ X-rays taken ☐ Yes ☐ No

Does your child eat between meals? ☐ Yes ☐ No

Does your child eat sweets such as candy, chewing gum, sports drinks, soda pop? ☐ Yes ☐ No

When does your child brush teeth? ☐ Upon arising ☐ After any food ☐ Right after meals ☐ Bed time

How does your child receive fluoride?

☐ Community water ☐ Well water ☐ Fluoride drops or tablets ☐ Fluoride rinse or gel

Has your child ever had ☐ Cavities ☐ Extractions ☐ Space maintainers ☐ Sealants ☐ Tooth injury

Has your child had any problems with dental treatment in the past? ☐ Yes ☐ No

If yes, please explain ____

Has anyone in your family, including parents, had orthodontics? ☐ Yes ☐ No

Has your child ever received a local anesthetic? ☐ Yes ☐ No

Does your child think there is any thing wrong with his teeth? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

If I ever have any change in my health, I will inform Dr. Fong at the next appointment without fail.

____ Date: ____________________

Signature of Patient, or Guardian

CHILD MEDICAL DENTAL HISTORY

OFFICE OF DAN FONG, DDS