MEDICAL AND DENTAL HEALTH QUESTIONNAIRE

Today's Date: _____ _____ _____
Day *Month* *Year*

General Information:

Name: _____ Birth Date: _____ _____ _____
Day *Month* *Year*
Address: _____
City: _____ Province: _____ Postal Code: _____
Telephone: _____
Father's name: _____ Occupation: _____
Employed by: _____ Work Phone: _____ Cell Phone: _____
Mother's name: _____ Occupation: _____
Employed by: _____ Work Phone: _____ Cell Phone: _____
Alternate emergency contact person: _____ Phone Number: _____
Family physician or pediatrician: _____ A.H.C. #: _____
Child's former dentist: _____
Name of person responsible for this account: _____
Do you have dental insurance? _____ Company name: _____
Group policy number _____ I.D. number: _____
Do you have a second dental plan or any other type of coverage? _____ Group policy number: _____
I.D. Number: _____ Insuring Company: _____
Whom may we thank for referring you? _____

Child's History:

Age: _____ Height: _____ Weight: _____ Male: ____ Female: ____
School: _____ Are you seeking treatment for any particular reason and/or routine dental care? _____

Medical History:

1. When did your child last visit the physician? _____
   Reason: _____
2. Has your child ever had any serious illness or been in the hospital? _____
   Describe: _____
3. Is your child taking any medications? _____ If so, describe: _____
   _____
4. Has your child ever had any of the following? Please circle:

Measles	Asthma	Shortness of breathe	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
Jaundice	Fainting spells	Tonsils removed	Adenoids removed	Liver disease
Cancer	Ankle swelling	Ear trouble	Abnormal blood pressure	
Physical deformity		Other		

5. Does your child have any allergies? _____ Describe: _____
6. Does your child have a heart murmur? _____
7. Does he or she bruise easily or bleed profusely for a long period of time? _____
8. Does your child have any blood disease? _____
9. Does your child play contact sports? _____ Describe: _____
10. Is your child now taking, or has he or she had: _____
    Penicillin: _____ Other antibiotics: _____ Cortisone: _____
    Local anesthesia: _____ General Anesthesia: _____ Other drugs: _____
11. Has he or she had any unfavorable reaction to these drugs? _____
12. Is there a history of any inherited diseases in the family? _____ If so, describe: _____
    _____

Medical History:

1. Has your child had previous dental care? _____ Last visit _____
2. Has he or she ever had an unpleasant experience associated with dental treatment? _____
   Describe: _____
3. Has your child ever had an accident, injury or surgery about the mouth? _____
4. Is there a family history of: (Please circle, if yes)

High decay rate	Missing teeth	Cleft lip/or palate
Tooth deformity	Extra teeth	Gum disease
Spaced teeth	Crooked teeth	

5. Does your child have any oral habits such as: (Please circle, if yes)

Thumb sucking	Nail biting	Chewing (e.g. pencils)
Finger sucking	Mouth breathing	Tongue thrusting
Lip biting		

6. Has your child ever had orthodontic treatment? _____
7. How often does your child brush his or her teeth? _____
8. Do you supervise tooth brushing? _____
9. Has your child ever received fluoride supplements in the diet or water supply? _____
10. Were his or her teeth ever treated with decay preventing topical fluorides? _____

Additional Information:

If there is any specific problem regarding your child's oral health which concerns you, or if there is any additional information which you feel may be helpful in our care of your child, please state below:

_____

Medical questionnaire update:

Please note any medical changes your child may have and sign below:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____
6. _____ Date: _____

Signed: _____
Father/Mother/Guardian