GREGORY D. CAMFIELD D.M.D., P.C.
Restorative - Aesthetic Dentistry

PEDIATRIC MEDICAL & DENTAL HISTORY (Under 18)

Patient Name:_____ Nickname:_____Age:_____

Height_____ Weight_____

MEDICAL HISTORY

Physician's Name:_____Date of Last Physical:_____

Physician's address:_____
Physician's Phone #:_____

- Has there been any change in the patient's general health within the last year? _____Y ____N
- Is the patient now under the care of a physician (other than routine check up?) If so, what is being treated?_____Y_____N

_____
_____

- Has the patient had a serious illness/ hospitalization in the past 5 years? If so, what for? ___Y____N

_____
_____

ALLERGIES OR DRUG REACTIONS TO:

* Latex Y____N____	* Penicillin or other antibiotics Y____N____	* Sulfa drugs Y____N____
* Aspirin, Ibuprofen, Tylenol Y____N____	* Local Anesthetic Y____N____	* Codeine Y____N____
* Flouride Y____N____	* Nuts, Milk, Fruit Y____N____	* Red Dye Y____N____
* Other Y____N____	* Chlorhexidine Y____N____	

IF Yes , Please
list:_____

_____

PLEASE SELECT **YES** IF THE PATIENT HAS HAD ANY OF THE CONDITIONS LISTED BELOW, EITHER NOW OR IN THE PAST. CANNOT BE BLANK

* Heart Murmur Y____N____	* Damaged or artificial heart valve Y____N____	*Congenital Heart defect Y____N____

* Heart Disease	* Rheumatic Fever	* Heart Attack/Stroke
Y____N____	Y____N____	Y____N____
* Angina *	* Liver Disease/Jaundice/	* Kidney disease
Y____N____	Hepatitis Y____N____	Y____N____
* Bleeding Disorder	* Prolonged Bleeding	* Arthritis/Joint problems
Y____N____	Y____N____	Y____N____
* Prosthetic Joints	* Bone fractures	* Growth Problems
Y____N____	*Y____N____	Y_____N____
*Asthma	* Sinus Problems	* Respiratory Problems
Y____N____	Y____N____	Y____N____
* Pneumonia	* Cancer	* Radiation Treatment
Y____N____	Y____N____	Y____N____
* Epilepsy/ Seizures	* Seasonal Allergies	* Persistent Cough
Y____N____	Y____N____	Y____N____
* Thyroid Problems	*Stomach problems/GERD	* Skin Disorder
Y____N____	Y_____N____	Y____N____
* Chronic Ear infections	* Hearing impairment	*Eye problems
Y____N____	Y____N____	Y____N____
* Chronic fatigue/ sleep disorder	* Tobacco, Drug or Alcohol use	* Frequent Headaches
Y____N____	Y____N_____	Y____N____
*Diagnosed with ADD, ADHD or Hyperactivity	* Treated for emotional problems	* Bed Wetting
Y____N____	Y____N____	Y____N____
* Jaw or Face Trauma	* Tonsils or Adenoids removed	* Growth Problems
Y____N____	Y____N____	Y____N____

IF ANY OF THE ABOVE MEDICAL QUESTIONS WERE ANSWERED 'YES", PLEASE EXPLAIN:

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in the patient's medical status.

Signature of Parent or Guardian:_____

Date:_____

DENTAL HISTORY

Previous Dentist:_____Date of most recent Dental exam?_____

Date of most recent Dental X-rays?_____

What is your Immediate Dental Concern?

_____

_____

PLEASE SELECY **YES** IF THE PATIENT HAS ANY OF THE CONDITIONS LISTED BELOW EITHER NOW OR IN THE PAST?

* Discomfort from teeth or gums?

Y____N____

* Chipped or Broken teeth?

Y____N____

* Food traps between teeth?

Y____N____

* Bad taste/mouth odor?

Y____N____

* Root canal(s)/ Pulpotomy?

Y____N____

* Pain in Jaw?

Y____N____

* Missing teeth?

Y____N____

*Teeth Extracted?

Y____N____

* Injury to Face or Jaw?

Y____N____

*Abnormal swallowing (tongue thrust)?

Y____N____

* Frequent Headaches?

Y____N____

* Snores during sleep?

Y____N____

*Grind/Clinch teeth (awake or asleep)?

Y____N____

* Have a tongue tie?

Y____N____

* Bite problem?(underbite, overbite, crossbite)?

Y____N____

* Thumb sucking, lip/nail biting?

Y____N____

* Frequent sore throats?

Y____N____

* Clicking or popping jaw?

Y____N____

* Speech problems/therapy?

Y____N____

* Mouth breathing?

Y____N____

* Have wisdom teeth been removed?

Y____N____

Frequently chews gum?

Y____N____

* Have had a Flouride treatment before?

Y____N____

* Have had numerous fillings before?

Y____N____

* Patient brushes teeth daily?

Y____N____

* Patient flosses teeth daily?

Y____N____

Patient has had an Orthodontic Consultation or treatment?

Y____N____ If Yes, please give Orthodontist name and phone #:

_____

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

Signature of Parent or Guardian:_____
Date:_____