TAPM Medical and Dental History Form

Child's name: _____ **Date of Birth:** _____ **Date:** _____

Medical and Dental History

Your child's overall health, as well as any medications that he/she takes, may have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Medical History

Child's Physician: _____

Physician's Address: _____

_____

Date of Last Physical: _____

_____

Has your child ever had any of the following?

Asthma	yes	no
Cancer/Tumors	yes	no
Hepatitis	yes	no
HIV/Aids	yes	no
Hemophilia	yes	no
Diabetes	yes	no
Kidney Problems	yes	no
Liver/GI Problems	yes	no
Endocrine Abnormalities	yes	no
Allergies (seasonal)	yes	no
Allergies (food, drug)	yes	no

Explain

Hearing Problems	yes	no
Eye Disorders	yes	no
Breathing/Lung Problems	yes	no
Blood Disorders	yes	no
Adverse Drug Reaction	yes	no
Rheumatic Fever	yes	no
Congenital Heart Defect	yes	no
Congenital Birth Defect	yes	no

Mental/Physical

Development Delays	yes	no
Behavioral/Learning Problems	yes	no
Seizures/Epilepsy	yes	no
Social Development Delays	yes	no
Recurrent/Freq. Headaches	yes	no
Tuberculosis	yes	no
Frequent Infections	yes	no
Significant Injuries	yes	no

Child's Medications

Please list your child's medications & dosages:

_____

_____

_____

_____

Dental History

What are your main concerns about your child's dental health?

How frequently are your child's teeth brushed? _____

How frequently are your child's teeth flossed? _____

Do you help your child with brushing/flossing? Yes No

Date of last dental visit_____x-rays

Previous Dentist

How would you describe your last dental experience?

Does your child have a healthy diet?

Does your child's family have a history of dental decay or gum disease? yes no

Is your child's drinking water fluorinated? yes no

Does your child take fluoride supplement? yes no

If yes, dosage:

Does your child:

Suck thumb/finger/lips/pacifier?	yes	no
Bite/chew nails or hard objects?	yes	no
Grind teeth/clench jaws?	yes	no
Use a bottle/sippy cup?	yes	no
Breast feed/how long?	yes	no
Eat/drink after brushing?	yes	no
Brush before bed?	yes	no

Drink more than 1 glass of juice, tea, soda, or sports drink per day? yes no

Have a history of dental trauma? yes no

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Explain _____

Hospitalizations yes no
Explain _____

Abnormal Bleeding yes no
History of Blood Transfusion yes no

Date _____

Heart Ailments yes no
Heart Murmur yes no

Type _____

Premed Needed yes no

Please explain any other medical problems that your child has _____
_____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to my child during the period of such dental care to third party payers and/or health practitioners. I also consent to any necessary radiographs (x-rays) needed for proper diagnosis.

X _____
Signature of parent/guardian date

X _____
Reviewed by TAPM date