Health History - Child
Douglas G. Drewyer, D.D.S., M.A., L.L.C.

We want you to know how very important it is that you provide a full disclosure of your child's total health profile, including history of past and present illness, allergies, and medications (prescription, over the counter and herbal or homeopathic).

There is a direct and powerful relationship between the extent of information you provide and our ability to provide full and responsible support of your child's continued health.

As always, your family's privacy is assured and your information is protected.

Yours in wellness,
Dr. Drewyer and Staff

Date:___/___/___

Name:____
First MI Last

Birthdate:___/___/___

DENTAL HISTORY

Please state briefly the reason for your visit:

____

Does the child have any mouth discomfort/concerns?

____

Is this the child's first visit to a dentist? Yes No
If no, how long since last dental visit?____________________
Are any teeth sensitive to hot/cold/biting/sweets? Yes No
If the child is under the age of 6, does the parent/guardian brush the child's teeth or supervise brushing? Yes No
Do gums bleed on brushing? Yes No
Does the child grind teeth in sleep? Yes No
Is there anything displeasing about the child's smile? Yes No
Have there been any injuries to the teeth (falls, blows, chips, etc.)?
Yes No If yes, please explain briefly:

____

____

more questions on the back>>>>>>>>>>>>>

Have there been any injuries to the face or mouth?
Yes No If yes, please explain briefly:

____

____

Has the child had any unfavorable dental experiences in the past?
Yes No
Has the child ever sucked a thumb or fingers? Yes No
Until what age:_______
Does the child have any speech problems?
Yes No If yes, please explain briefly:

____

Is the child a mouth breather? Yes No
While awake/asleep or both:______________
Does the child wake up with a dry mouth? Yes No
Has either parent had orthodontic treatment? Yes No
List any musical instruments played:

____

MEDICAL HISTORY

Child's physician's and/or healer's name and address:

____

____

____

Is the child in good health? Yes No
Does the child have any history of major illness? Yes No
If yes, please explain briefly:

____

Has the child had any emergency hospitalizations in the past 5 years?
Yes No If yes, please explain briefly:

____

Is the child under medical treatment at this time?
Yes No If yes, please explain briefly:

____

List any allergies or drug sensitivity (ex. Penicillin, Amoxicillin, Erythromycin, Clindomycin, Local anesthesia, foods, or any over-the counter medications).____________________________________

____

Is the child taking any drugs or medications at this time? Yes No
If yes, please list medications: ________________________________

____

Does the child have a tendency of getting:

Colds	Yes	No	
Sore throats	Yes	No	
Ear infections	Yes	No	
Cold sore/canker sore	Yes	No	

Have tonsils and/or adenoids been removed? Yes No

If yes, at what age:______

Does the child snore? Yes No

Does the child have a history of any of the following:

Asthma	Yes	No	
Rhuematic Fever	Yes	No	
Heart murmur	Yes	No	Type:_______
Artificial heart valve	Yes	No	
Diabetes	Yes	No	Type:_______
Hepatitis	Yes	No	Type:_______
Hemophilia	Yes	No	
Tumors/growths	Yes	No	
Cancer	Yes	No	Type:_______
Epilepsy	Yes	No	
AIDs or AIDs related complex	Yes	No	
ADHD	Yes	No	
Fainting or dizziness	Yes	No	

If there are **any** other medical conditions or health problems that are not listed above, please explain: ____

____

____

Signature:____

(Parent or Guardian)