

Dr. Jepsen & Associates

A Professional Corporation
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CHILD HISTORY QUESTIONNAIRE

PATIENT MEDICAL HISTORY

Child's Name: _____ Birth date: _____ Age: _____ Gender: M / F _____

Name and address of physician: _____

Date of your child's last medical exam: _____

Findings? _____

Does child have any illness now? _____

Has your child ever been hospitalized? () yes () no If so, when? _____

Has your child ever had surgery? () yes () no If so, when/what reason? _____

Is your child presently under a physician's care? () yes () no If so for what? _____

Allergic to any medication or allergic to anything else? _____ Type of Reaction? _____

Taking any medicine? _____ Explain _____

Dose of medicine: _____

Do you want your child to have Nitrous Oxide Sedation? () yes () no

Has child had any history of (circle those that apply)

AIDS	Breathing Problems	Eye or Sight Problems	Liver Disease
Anemia	Congenital Birth Defects	Excessive Bleeding	Lung Disease
Asthma	Convulsion/Seizures	Hearing Problem	Mental Retardation
Bacterial/Viral Infection	Diabetes	Heart Murmurs	Recurrent Headaches
Behavioral Problems	Digestive System Disorders	Heart Troubles	Rheumatic Fever
Blood Disease	Emotional Problem	Jaundice	Speech Impediment
Blood Transfusions	Endocrine System Disorders	Kidney Problems	Temporal Mandibular Joint Problems
	Epilepsy	Learning Problems	Tuberculosis
			Tumors/Cancer

Dates of Blood Transfusions: _____

Others (please list): _____

Is this: First visit to a Dentist? () yes () no An Emergency? () yes () no

What is your reason for bringing your child in for dental care? _____

Date of last dental visit and X-Rays: _____

Is there now or has there ever been any of the following? (please circle)

Cavities	Toothache	Pain	Broken Tooth
Extracted Teeth	Straightened Teeth	Gum Infection	Mouth Injuries

Does child have a history of: (Please circle)

Thumb Sucking	Finger Sucking	Lip Sucking	Teeth Grinding
Prolonged use of bottle and /or breast feeding		Nail Biting	Pacifier

Has your child had an unfavorable medical or dental experience? () yes () no

If yes, please explain: _____

- Does your child brush regularly? () Yes () No
- Does your toothpaste contain fluoride? () Yes () No
- Does your child use dental floss? () Yes () No
- Is your child's water fluoridated? () Yes () No
- Does your child uses fluoride rinses or supplements? () Yes () No

Please add anything concerning your child's dental or medical history that you feel may be important: Including Social Development (Personality/Temperament): _____

INFORMED CONSENT

The permission of the parent or guardian is necessary for dental treatment of a minor.

I give the doctor permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include, an oral examination, radiographs (x-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood, or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

Signature _____ Relationship to child _____ Date _____

Reviewed by Doctor _____ Date _____

HEALTH HISTORY UPDATE

1. Comments _____
Recorded by _____ Date _____
2. Comments _____
Recorded by _____ Date _____
3. Comments _____
Recorded by _____ Date _____
4. Comments _____
Recorded by _____ Date _____