



Richard B Dunn, D.D.S.

Prakash (Paul) Thuraiamy, D.D.S.

### CHILDREN'S MEDICAL HEALTH HISTORY

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent's Name \_\_\_\_\_ Home Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Referred To Us By: \_\_\_\_\_

School: \_\_\_\_\_

Dental Insurance Co. Name: \_\_\_\_\_

Most Convenient Day & Time For Your Dental Appointments: \_\_\_\_\_

Purpose of This First Dental Visit: \_\_\_\_\_

Person Financially Responsible For This Account: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employment Name & Address: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

**Please check the best answer, and complete the blank lines where appropriate:**

- Is this the patient's 1<sup>st</sup> visit to any dentist? . . . . .  Yes  No
- Is he (she) under medical treatment now? . . . . .  Yes  No  
In the past year? If YES, for what? \_\_\_\_\_
- Does he (she) brush his teeth less than twice a day? . . . . .  Yes  No
- Does he (she) have any allergies? . . . . .  Yes  No
- Is he (she) allergic to any particular medications? . . . . .  Yes  No
- Has he (she) ever had a reaction to Novocaine/local anesthesia? . . . . .  Yes  No
- Does he (she) have frequent nose bleeds? . . . . .  Yes  No
- Is he (she) taking any medication now? . . . . .  Yes  No
- Has he (she) had a recurring sore throat? . . . . .  Yes  No
- Is he (she) considered a nervous person? . . . . .  Yes  No
- Does he (she) eat between meals? . . . . .  Yes  No
- Has he (she) ever had a sever toothache? . . . . .  Yes  No
- Has he (she) had any injuries to his (her) teeth? . . . . .  Yes  No
- Has he (she) gained or lost much weight lately? . . . . .  Yes  No
- Check if your child ever had:  rheumatic fever;  diabetes;  epilepsy;  thursh;  
 anemia;  kidney trouble;  liver trouble;  heart trouble;  hepatitis;  asthma;  
 tuberculosis;  circulatory, bleeding problems;  immune system diseases?  
other illnesses . . . . .  Yes  No  
If YES, what: \_\_\_\_\_
- Does he (she) have any mouth habits? . . . . .  Yes  No
- How long since he (she) has been to a dentist? \_\_\_\_\_
- What was done at this visit? . . . . .  Yes  No
- Did he (she) make regular visits before then? . . . . .  Yes  No
- Did he (she) have X-rays taken regularly? . . . . .  Yes  No
- How often does he (she) brush his (her) teeth? \_\_\_\_\_ When: \_\_\_\_\_