Brampton Dental Arts
Where we create smiles

CHILD MED HISTORY - HEALTH/DENTAL FORM

PATIENT'S NAME *
First Name Last Name

DATE OF BIRTH *
Month Day Year

SEX *
Male Female

PARENT/ GUARDIAN NAME *
First Name Last Name

ADDRESS
Street Address
Street Address Line 2
City State / Province
Postal / Zip Code

PHONE HOME
Area Code Phone Number

PHONE OFFICE
Area Code Phone Number

MOBILE
Area Code Phone Number

EMAIL *
example@example.com

Have you or patient had any of the following diseases or problems *

Yes No

1. Active TB,
2. Persistent Cough for longer than 3 wks
3. Cough that produces blood?

If you answered yes to any of the above, please stop & return this form to the front desk.

Has the child had any history of:

- Anemia
- Mononucleosis
- Fainting
- Asthma
- Rheumatic Fever
- Latex Allergy
- Heart
- Hepatitis
- Cancer
- Sickle Cell
- Immunizations
- Chicken Pox
- Tuberculosis
- Seizures
- Liver
- Measles
- Epilepsy
- Arthritis
- Mumps
- Growth Problems
- Bladder
- Bleeding Disorders
- Bones/Joints
- Hearing
- HIV/AIDS
- Cerebral Palsy
- Thyroid
- Kidney
- Chronic Sinusitis
- Diabetes
- Ear Aches
- Other

NAME OF FAMILY DOCTOR

First Name Last Name

PHONE #

Area Code Phone Number

Is your child taking any prescription or over the counter drugs or vitamins?

◯Yes ◯No

If yes, please list

Is your child allergic to any medications?

◯Yes ◯No

Does your child any food allergies?

◯Yes ◯No

How would you describe your child's eating habits?

Has your child ever had a serious illness?

◯Yes ◯No

Has your child ever been hospitalized?

◯Yes ◯No

Has your child ever had general anesthetic?

◯Yes ◯No

Does your child have a history of any other illness?

◯Yes ◯No

Does your child have any speech difficulties?

◯Yes ◯No

Has your child ever had a blood transfusion?

◯Yes ◯No

Is your child physically, mentally or emotionally impaired?

◯Yes ◯No

Does your child experience excessive bleeding?

◯Yes ◯No

Is you child currently being treated for any illness?

◯Yes ◯No

Is this your child's first dental appointment?

◯Yes ◯No

If not, when was their last visit?

Who was their last dentist?

Has your child had any problems with past dental treatment?

◯Yes ◯No

Has your child ever had dental x-rays taken?

◯Yes ◯No

Has your child ever suffered any injury to head, mouth or teeth?

◯Yes ◯No

Has your child had any problems with eruption or shedding of his teeth?

◯ Yes ◯ No

Has your child had any orthodontic treatment?

◯ Yes ◯ No

What type of water does your child drink:

☐ city ☐ well ☐ bottled ☐ filtered water

Does your child take Fluoride supplements?

☐ Yes ☐ No

Is Fluoride toothpaste used?

☐ Yes ☐ No

How many times are your child's teeth brushed per day?

Does or did your child suck their thumb, fingers or pacifier?

☐ Yes ☐ No

At what age did your child stop bottle feeding? Age

Breast feeding? Age

Does your child participate in recreational activities?

☐ Yes ☐ No

Note: We encourage you to discuss any and all relevant patient health issues prior to treatment.
I certify that I have given answers to the above questions to the best of my knowledge. I will not hold Dr. Sheikh or any of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

Parent's/Guardian's Signature

Date:

Month Day Year