

Wilmington Dental Care
General Dentistry for Youth
 first tooth through age 20

Health History

Patient's Name: First Last

Date of birth: Month Day Year

Dental History:

What brings you to the dental office today?

How long since the patient's last dental visit? 6 months more than 6 months more than a year never

Does the patient have any dental pain at this time? Yes No If yes, please explain

How often does the patient brush? once per day twice per day sometimes never

How often does the patient floss? once per day twice per day sometimes never

Does the patient have any of the following oral habits?

Suck their finger, thumb or pacifier Nail Biting Lip Sucking Biting Grinding

Is the patient breast feeding? Yes No or still on the bottle? Yes No

Has the patient experienced a history of trauma or falls involving the face or teeth? Yes No If yes, please explain

Medical History:

	<u>Yes</u>	<u>No</u>
Is the patient under the care of a specialist now? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever been hospitalized or had a major operation? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever had a serious head or neck injury? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient on a special diet? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient use tobacco? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient use controlled substances? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient pregnant or trying to get pregnant? If yes, how many weeks? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
When was the patient's last checkup with their physician? <input type="checkbox"/> within a year <input type="checkbox"/> more than a year <input type="checkbox"/> never		
List all medications, pills or drugs currently taken <input type="text"/>		

Please mark the boxes below if the patient is allergic to any of the following:

Aspirin Penicillin Codeine Latex Metal Sulfa

Does the patient have any other allergies? Please list

Health History (Continued)

Does the patient have or have they ever had any of the following?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mental health care	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve or Joint	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Growth Problems	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Autism/Spectrum disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia or Trait	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impaired	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or other gland disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B or C	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>	Vision impaired	<input type="checkbox"/>	<input type="checkbox"/>
Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Limitations in using arms or legs	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Problem	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>			

Does the patient have any other medical condition not listed above?

Comments:

X _____

Signature of Parent/Legal Guardian