Emily Bland D.D.S

EmilyBlandDDS.com office@emilyblanddds.com

6080 Lake Murray Blvd., Ste. B • La Mesa, CA 91942 (619)460-0911

Child Health / Dental History

Patient's Name:

Date of Birth: ______________

Gender

◯ Male ◯ Female

Parent's / Guardian's Name:

Relationship to Parent:

Address:

City

State:

Zip Code:

Phone Number

Home:

Work:

Have you (the parent/guardian) or the patient had any of the following diseases or problems?

Active Tuberculosis ◯ Yes ◯ No

Persistent cough greater than a three week duration ◯ Yes ◯ No

Cough that produces blood ◯ Yes ◯ No

If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of , or condition related to, any of the following:

- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma
- [ ] Autism Spectrum Disorder
- [ ] Attention Deficit Disorder (ADD)
- [ ] Attention Deficit Hyperactivity Disorder (ADHD)
- [ ] Bladder
- [ ] Bleeding Disorder
- [ ] Bones/Joints
- [ ] Cancer
- [ ] Cerebral Palsy
- [ ] Chicken pox
- [ ] Chronic Sinusitis
- [ ] Diabetes
- [ ] Earaches
- [ ] Epilepsy
- [ ] Fainting
- [ ] Growth Problems
- [ ] Heart
- [ ] Hepatitis
- [ ] HIV/AIDS
- [ ] Immunizations
- [ ] Kidney
- [ ] Latex Allergy
- [ ] Liver
- [ ] Measles
- [ ] Mononucleosis
- [ ] Mumps
- [ ] Pregnancy (Teens)
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] Sickle Cell
- [ ] Thyroid
- [ ] Tobacco/Drug Use
- [ ] Tuberculosis
- [ ] Venereal Disease
- [ ] Other

Please list the name and phone number of the child's physician

____

____

Date of last physical exam:

____

____

Child's History

Is the child taking any prescription and /or over the counter medications or vitamin supplement? ◯ Yes ◯ No

If yes please list:

____

____

Is the child allergic to any medications i.e. Penicillin, antibiotics, or other drugs? ◯ Yes ◯ No

If yes please explain:

____

____

Is the child allergic to anythig else, such as certain foods? ◯ Yes ◯ No

If yes explain:

____

____

How would you describe the child's eating habits?

____

____

Has the child ever had a serious illness? ◯ Yes ◯ No

If yes , when and please describe:

Has the child ever been hospitalized? ◯ Yes ◯ No

If yes, when and please describe:

Has the child have a history of any other illlnesses? ◯ Yes ◯ No

If yes please list:

Has the child ever received a general anesthesia? ◯ Yes ◯ No

If yes, please describe:

Does the child have any inherited problems? ◯ Yes ◯ No

Does the child have any speech difficullties? ◯ Yes ◯ No

Does the child ever had a blood transfusion? ◯ Yes ◯ No

Is the child physically, mentally, emotionally, impaired? ◯ Yes ◯ No

If yes, please describe:

Does the child experience excessive bleeding when cut? ◯ Yes ◯ No

Is the child currently being treated for any illnesses? ◯ Yes ◯ No

If yes, please describe:

Is this the child's first visit to the dentist? ◯ Yes ◯ No

If not ,what was the date of the last dental visit?

Has the child had any problem with dental treatment in the past? ◯ Yes ◯ No

Has the child ever had a dental x-ray exposed? ◯ Yes ◯ No

If yes, date taken:

Has the child ever suffered any injuries to the mouth, head or teeth? ◯ Yes ◯ No

If yes, please describe:

Has the child had any problems with the eruption or shedding of teeth? ◯ Yes ◯ No

Has the child had any orthodontic treatment? ◯ Yes ◯ No

Does the child suck on his/her thumb, fingers, or pacifier? ◯ Yes ◯ No

What type of water does your child drink?

☐ city water ☐ well water ☐ bottled water ☐ filtered water

Is fluoride toothpaste used? ◯ Yes ◯ No

Does the child take fluoride supplements? ◯ Yes ◯ No

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

When are the teeth brushed?

Do you floss your child's teeth? ◯ Yes ◯ No

If yes, how often?

At what age did the child stop bottle feeding? Age:

Breastfeeding? Age:

What is your reason for your visit today?

How often does your child visit the dentist?

Name of former Dentist :

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Parent's /Guardian's Signature

Response Date: ___________