Jenifer Wolfe, DDS

Dental Health Questions (age 0-7)

A child's dental health is affected by many different things. To help us better evaluate your child's dental health, please answer the following questions.

Child's Name: ____

Home Dental Care

How often does your child brush? ________________

Does your child use a manual toothbrush or electric toothbrush? ______________

Is toothbrushing supervised? Yes No

What kind of toothpaste is used? ________________________

Do you floss your child's teeth? Yes No

Does your child drink well water, bottled water, or city water?________________

Do you have a water filter? Yes No

Dental History

Is this your child's first dental visit? Yes No

If no, date of Last Dental Visit: ________________ Date of Last X-Rays: _________________

Any injuries to your child's teeth or jaws? Yes No

If yes, explain?____

History of:	When?
Breast feeding	__________________
Bottle feeding	__________________
Thumb or Finger sucking	__________________
Pacifier	__________________
Dental grinding or clenching	__________________

Has there been any unfavorable reaction from previous medical or dental care? Yes No

If yes, please explain:____

Has your child had recent dental pain? Yes No

Diet

Was/is your child put to bed with a bottle? Yes No
If yes, what was/is in the bottle? ____

Was/is your child allowed to carry a bottle or cup throughout the day containing something other than plain water? Yes No

How many meals per day does your child eat? ________________

How many snacks does your child have on an average day?___________

Please list some favorite/frequent snacks: ____

Please list some favorite/frequent drinks: ____

How did you hear about us?

____

Phone: 515.967.9790 | Fax: 515.967.1425 | 125 24th Street SE, Altoona, IA 50009 |
AltoonaPediatricDental.com

Health History

Patient Name ________________________________ Gender M F Birthdate__________

Is your child presently under the care of a physician? Yes No If yes, what for? ______________________________
FAMILY PHYSICIAN'S NAME________________________ PHONE NUMBER ____________________
DATE OF LAST PHYSICAL EXAM ____________________
Is your child presently under the care of a medical specialist? Yes No If yes, what for? ________________________
SPECIALIST'S NAME______________________________ PHONE NUMBER_____________________
Does your child have a history of health problems? Yes No If yes, Explain. _________________________________
Are antibiotics required for dental work? (heart murmur, heart defect, prosthesis, shunt or other reason) Yes No
Is your child presently taking any medications? Yes No
If yes, please list____
Has your child had a history of taking medications frequently? Yes No
Which ones?
____
Has your child ever been hospitalized or had surgery? Yes No
What For?
____
Is your child allergic to any medications? Yes No If yes, what? ____
Is your child allergic to any dyes or foods? Yes No If yes, what? ______________________________________
Is your child allergic to metals (Snaps)? Yes No
Is your child allergic to latex? Yes No
Has any member of the family, including your child, had a problem with a general anesthetic? Yes No
If yes, explain____

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO:

Y N
O O AIDS - HIV
O O Acid Reflux
O O Anemia
O O Arthritis
O O Asthma, If yes, what triggers it?
____
O O Autism
O O Bladder Conditions
O O Blood Disease
O O Blood Transfusions
O O Birth Defects
O O Bone or Joint Problems
O O Brain Injury
O O Bruising Easily
O O Cancer or Malignancies
O O Cerebral Palsy
O O Chemotherapy/Radiation
O O Child Abuse
O O Chronic Adenoid/Tonsil Infection
O O Chronic Ear Infections
O O Cleft Lip/Palate
O O Congenital Heart Lesion
O O Convulsions/Seizures
O O Developmentally Delayed
O O Diabetes
O O Drug Addiction
O O Ear Stuffiness, Itching or Noises
O O Emotional Disturbance
O O Epilepsy
O O Eye Problem

Y N
O O Excessive Bleeding Problem
O O Excessive Gagging
O O Fainting or Dizziness
O O Fever Blisters or Cold Sores
O O Growth & Development Problems
O O Heart Surgery
O O Headaches
O O Hearing/Speech Impairments
O O Heart Murmur/Defect
O O Hemophilia
O O Hepatitis or Liver Disease
O O High Blood Pressure
O O Hyperactivity/ADD
O O Kidney Disease
O O Leukemia
O O Mental Disability
O O Mouth Sores
O O Orthopedic Problems
O O Pain in Jaw Joints
O O Premature Birth
O O Psychiatric Care
O O Rheumatic Fever
O O Scoliosis
O O Sickle Cell Anemia
O O Syndrome ________________________
O O Thyroid Problem
O O Tuberculosis
O O Other________________________

Signature ________________________________ **Date** ________________
Relationship to Child ______________________________
Reviewed by Doctor _______________________________