Altoona Pediatric Dental

Jenifer Wolfe, DDS

Dental Health Questions (age 8+)

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? _____

What kind of toothpaste is used? _____

Is dental floss used? 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?_____

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

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 _____