Joseph L. Rumfola, DDS **Patient Name:**___________________________________

CHILD MEDICAL/DENTAL HISTORY QUESTIONNAIRE

Weight _______ Height________ Date of birth _________

Is your child currently under the care of a physician for ongoing treatment? ❑ Yes ❑ No

Physician's name: ______________________________________ Physician's Telephone #: __________________________

Physician's address: ____

Your child's last physical examination was: ________________________

Does your child have, or has he/she had any of the following conditions: (Please circle all that apply)	Yes	No	Not sure
1. Rheumatic fever, rheumatic heart disease, heart murmur or mitral valve prolapse?	❑	❑	❑
2. Cardiovascular disease (heart attack, angina, coronary bypass, high blood pressure, arterial sclerosis, stroke, pace maker)?	❑	❑	❑
3. Allergic reactions to food/drugs, asthma, fainting spells, seizures, or frequent headaches?	❑	❑	❑
4. Diabetes, hepatitis, liver disease, osteoporosis, stomach ulcers, kidney disorder or arthritis?	❑	❑	❑
5. Thyroid disorder, cancer, surgery or radiation treatment of the head or neck ?	❑	❑	❑
6. Tuberculosis, HIV/AIDS, blood disorder (such as anemia)?	❑	❑	❑
Has your child had any abnormal bleeding from previous dental extractions, surgery or trauma?	❑	❑	❑
Has your child had any serious trouble associated with any previous dental treatment?	❑	❑	❑

Is your child allergic to, or has he/she reacted adversely to: (please circle all that apply)
local anesthetics (i.e. Novocain), penicillin or other antibiotics, aspirin, sulfa drugs, iodine, or latex?

Does your child have any disease, condition, or problem that you think I should know about, not listed above?

____

Is your child currently taking any medicine, vitamins, or herbal supplements? ❑ ❑

**** If yes, please bring a complete list noting name, dosage, and approximate date started.**

Chief dental complaint: ____

When was your child's last visit to a dentist? ____

What treatment did he/she receive? ____

Why did you leave your child's previous dentist? ____

How often does your child brush his/her teeth? _____________________ floss? _____________________

	Yes	No
Are you aware of any swelling, soreness, rough areas, ulcers, or color changes in your child's mouth?	❑	❑
Are your child's teeth sensitive to hot, cold, sweets, biting pressure?	❑	❑
Has your child ever had any teeth removed?	❑	❑
Does your child grind, clench, or grit his/her teeth?	❑	❑
Does your child have or has he/she had any pain in his/her jaw joint or muscles?	❑	❑
Do your child's gums bleed when brushing?	❑	❑
Does your child ever avoid any part of the mouth while brushing?	❑	❑
Does your child have an unpleasant taste or odor in his/her mouth?	❑	❑
Does your child brush his/her tongue?	❑	❑
Does your child experience dry mouth?	❑	❑
Does your child frequently snack on sweets between meals or chew gum?	❑	❑
Does your child play any sports in which a mouth guard would be beneficial?	❑	❑
Has the fear of discomfort kept your child from regular dental visits?	❑	❑
Has your child ever been instructed regarding proper dental home care?	❑	❑

All of the above information is for record keeping purposes only and will be considered confidential. By signing below, I certify that the above information is true to the best of my knowledge and agree to notify this office if there are any changes in my child's medical status.

_______________________________________ _______________________________________

Signature of Parent/Guardian Date Signature of Dentist Date

MEDICAL/DENTAL HISTORY QUESTIONNAIRE