KYDENTISTRY4KIDS.COM

WENDY K. HUMPHREY, D.M.D.
PEDIATRIC DENTISTRY
181 W. Lowry Lane, Suite 110
Lexington, KY 40503
859-277-5437

MEDICAL-DENTAL HISTORY

Name _____ Preferred Name _____ Sex _____

Birthdate _____ Age _____ Child's Physician _____ Date Last Seen _____

Physician's Address _____ Phone _____

Date of Last Physical Exam _____ Are immunizations up to date? _____

1. Condition of your child's health _____
2. Has your child recently undergone or is she/he undergoing any medical treatment? _____
3. Has your child ever been hospitalized, had an operation or been confined to bed for a long period of time? _____

   _____
4. Is any medical treatment anticipated in the future? _____
5. Does your child have any allergic reactions to any kind of medicine, latex or food? _____
6. Is your child presently taking any kind of medication? _____

   If yes, please list medication and dosage. _____
7. Does your child have any unusual fears? _____
8. Does your child have any history of:

_____ Allergies (seasonal)	_____ Brain Injury	_____ Autism / Aspergers
_____ Anemia	_____ Cancer	_____ ADD / ADHD
_____ Asthma	_____ Cerebral Palsy	_____ Down Syndrome
_____ Excessive Bleeding	_____ Diabetes	_____ Mental / Emotional Problems
_____ Hemophilia	_____ Epilepsy/Seizures	_____ Heart Disease
_____ HIV / AIDS	_____ Liver Disease / Hepatitis	_____ Heart Murmur:
_____ Sickle Cell Anemia	_____ Kidney Problems	___ Active ___ Functional
_____ Tuberculosis	_____ Rheumatic Fever	_____ High Blood Pressure

   Other (please specify) _____
9. Has your child ever had any hearing, sight, speech, or coordination problems? _____

   _____
10. Is there any additional medical information we should know? _____

    _____
11. Is this the first time your child has visited a dental office? Yes No
12. If not, how long since his/her last visit to the dentist? _____

Please Complete Both Sides

Over

13. If your child has previously been to the dentist, did he/she receive any of the following:

_____ Local anesthetic (Novocaine) _____ X-rays _____ Sedation

_____ Nitrous Oxide Analgesic (Laughing Gas) _____ General Anesthetic

Were there any unfavorable reactions? _____

14. Were there any acute dietary or medical problems during pregnancy such as : Measles, sickness with high fever, blood disorders (anemia), others? (please skip to question #15, if your child was adopted) _____

_____

15. Does your child have a history of:

_____ Thumb Sucking _____ Tongue thrusting _____ Lip or nail biting

_____ Pacifier _____ Mouth Breathing _____ Object biting

16. Has there been any injury to your child's teeth by a fall, blow, bump, or otherwise? _____

_____

17. Up to what age was your child using the night bottle or breast-fed? _____

18. Does your child use a sippy cup? Yes ____ No ____ How often _____

19. How often does your child brush his/her teeth? _____

20. Does your child consume excessive amount of any of the following:

____ Milk ____ Juice ____ Candy ____ Well Water ____ Bottled Water ____ Soda Pop

21. Is your child receiving fluoride supplements? Yes ____ No ____

22. Does your child drink? ____ City Water ____ Well Water ____ Bottled Water ____ Filtered Water

23. Has your child ever complained of:

_____ Toothache _____ Jaw joint sounds or pain _____ Frequent headaches

_____ Teeth sensitive to heat _____ Teeth sensitive to cold _____ Pain in ear

24. Are you concerned about any special dental problems now? _____

_____

25. Reason for seeking treatment at this time? _____

_____

26. Do you expect your child to be uncooperative? (if yes, please explain) _____

_____

Thank you for completing this personal history. The information which you supplied allows us to plan for your child's emotional and dental needs while making a thorough evaluation of his/her dental health.

The above statements are, to the best of my knowledge, true and correct. I authorize the treatment of this patient.

X _____

Signature of Parent or Guardian **Relationship to Patient** **Date**