Time 9:25 AM | Michael A. McCoy, D.D.S | Date 9/2/2020

Children's Dental/Medical History 2020

Patient Name: | Birth Date: | Date Created:

Dental Habits/ History

Does child use floss daily? How Many times per week?	Yes No	If yes	
Does child brush teeth daily?	Yes No	If yes	
Is fluoride taken in any form?	Yes No	If yes	
Any injuries to mouth, teeth, or head?	Yes No	If yes	
Any unhappy dental experiences?	Yes No	If yes	
Has child complained about dental problems?	Yes No	If yes	
Any mouth habits: thumb sucking, nail biting, mouth breathing, pacifier, sleeping with a bottle, etc.?	Yes No	If yes	

Medical History

Is child currently under care of a physician now?	Yes No	If yes	
Is child receiving any medication or drugs?	Yes No	If yes	
Has child ever been hospitalized?	Yes No	If yes	
Has child ever had a surgery?	Yes No	If yes	

Are you allergic to any of the following?

Aspirin	Yes No	Penicillin	Yes No	Codeine	Yes No	Acrylic	Yes No
Metal	Yes No	Latex	Yes No	Sulfa Drugs	Yes No	Local Anesthesia	Yes No

Other Please List | Yes No | If yes

Has child had any history of or difficult with any of the following? If yes, please check:

Aids/HIV	Yes No	Anemia	Yes No	Asthma	Yes No	Bladder Problems	Yes No
Cancer	Yes No	Cerebral Palsey	Yes No	Chicken Pox	Yes No	Diabetes	Yes No
Drug/Alcohol Abuse	Yes No	Epilepsy	Yes No	Fainting	Yes No	Hearing Problems	Yes No
Heart Murmur	Yes No	Gag Reflex	Yes No	Kidney Disease	Yes No	Liver Disease	Yes No
Hepatitis	Yes No	Measles	Yes No	Mumps	Yes No	Rhuematic Fever	Yes No
Sinus Problems	Yes No	Thyroid Disease	Yes No	Tuberculosis	Yes No	Convulsions	Yes No

Signature of Patient, Parent or Guardian:

X Date:_____