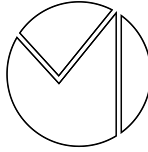

Children's Health Questionnaire

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

General Information:

Patients Name:____________________________________ Birth Date:_____________
____ (MM/DD/YY)

Address:____
City Province Postal Code

Preferred Telephone:________________________________ Email:____________________________

Father's Name:____________________________________ Contact Number:___________________

Mother's Name:____________________________________ Contact Number:___________________

Referred by:______________________________________

Medical History:

1. Family Physician or Pediatrician:____
2. When did your child last visit the Physician?____
   a. Reason:____
3. Has your child ever had any serious illness or been hospitalised?___________________________
4. Has your child ever had any of the following? Please circle all that apply:

Measles	Asthma	Shortness of Breath	Kidney Disease
Mumps	Hay Fever	Lung Disease	Diabetes
Chicken Pox	Heart Trouble	Tuberculosis	Broken Bones
Strep Throat	Chest Pains	Epilepsy	Operations
Tonsillitis	Fainting Spells	Liver Disease	Adenoids
Ankle Swelling	Physical Deformity	Hepatitis A B (circle one)	Ear Trouble
Jaundice	Cancer	High/low Blood Pressure	

5. Are there any conditions or diseases not listed above that your child has/has had?
   ____
6. Does your child have allergies to:
   a. Medications:____

b. Latex/rubber products:____

c. Other:____

7. Is your child taking any medications? If yes, please list. Yes No

____

8. Does your child bruise easy? Yes No

9. Does your child have any emotional concerns?___________________________________

Dental History

1. Has your child had previous dental care? Yes No If yes, when was their last:
   a. Dental checkup:________________ Office Name:_____________________
   b. Dental cleaning:________________
   c. Dental X-rays:_________________
2. Has your child had an unpleasant experience associated with dental treatment? Yes No
   a. If yes, please explain:____
3. Has your child ever had an accident, injury or surgery involving the mouth? Yes No
   a. If yes, please explain:____
4. Has your child ever had orthodontic treatment? Yes No
5. How often does your child brush their teeth?__________________________________
6. Do you currently supervise while they are brushing?_____________________________
7. It is the policy of our office to emphasize preventive dentistry. Do you agree with this approach?

   Yes No

Additional Information

If there is any specific concerns regarding your child's oral health or any additional information which you feel may be helpful in our care of your child, please state below:

____

____

____

Consent

This is to certify that I, _________________ consent to the performing of the dental and oral surgery procedures agreed to be necessary (including the use of general or local anesthetics as indicated). I will assume responsibility for all fees associated with all procedures.

Signature________________________________ ______________________

Parent/Guardian Date