NORTHERN TIER CENTER FOR HEALTH
NOTCH

Dental History Questionnaire - Pediatric

Name:_____ DOB: _____ Today's Date: _____

Parent/Guardian Name: _____ ☐ Parent ☐ Guardian

Previous Dentist: _____ Address: _____ Last Visit: _____

Primary Care Provider: _____ Address:_____ Phone: _____

Your child's overall health and medications he or she may be taking may impact the dental care your child receives. Please answer the following questions completely:

Does your child *(Check all that apply)*:

- ☐ Suck Thumb / Finger
- ☐ Suck / Bite lip
- ☐ Bite / Chew Nails
- ☐ Chew Hard Objects (Pencils, etc.)
- ☐ Grind Teeth
- ☐ Clench Jaws

	Yes	No
Is your child's water fluoridated?	☐	☐
Does your child take fluoride supplements?	☐	☐
Has your child had difficult with dental visits?	☐	☐

How often does your child brush? _____

How often does your child floss? _____

Please list any previous hospitalizations/surgeries, or serious illness: _____

Please list any medications your child is taking: _____

Does your child have a history of allergies / sensitivities / adverse reactions to any drugs or medications (e.g. penicillin, Novocain etc.)? ☐ ☐

If **YES**, please describe: _____

Does your child have a history of allergies to any other substance (latex, environmental, etc.)? ☐ ☐

If **YES**, please describe: _____

Medical History: *Does your child currently have, or has he or she had any of the following? (Check all that apply)*

- ☐ Asthma
- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Abnormal Bleeding
- ☐ Tuberculosis (TB)
- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ Congenital Heart Defect
- ☐ Heart Murmur
- ☐ Convulsions / Epilepsy
- ☐ Stomach, Liver, or Kidney Problems
- ☐ Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)
- ☐ Other (please list) _____

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. I hereby give my consent to treatment for the named patient (of whom I am the parent, legal guardian, or foster parent) to the Northern Tier Center for Health.

_____ _____

Signature of Parent or Guardian Date