Drewyer Dentistry Austin D. Drewyer, L.L.C. Douglas G. Drewyer, D.D.S., M.A.

Health History - Child

Yours in wellness, Dr. Drewyer and Staff

We want you to know how very important it is that you provide a full disclosure of your child's total health profile, including history of past and present illness, allergies, and medications (prescription, over the counter and herbal or homeopathic).

There is a direct and powerful relationship between the extent of information you provide and our ability to provide full and responsible support of your child's continued health.

As always, your family's privacy is assured and your information is protected.

Date: / / Name: MI Last Birthdate:___/___/___ DENTAL HISTORY Please state briefly the reason for your visit: Does the child have any mouth discomfort/concerns? Is this the child's first visit to a dentist? Yes No If no, how long since last dental visit?___ Are any teeth sensitive to hot/cold/biting/sweets? Yes If the child is under the age of 6, does the parent/guardian brush the child's teeth or supervise brushing? Yes No Do gums bleed on brushing? Yes No Does the child grind teeth in sleep? No Yes Is there anything displeasing about the child's smile? No Have there been any injuries to the teeth (falls, blows, chips, etc.)? Yes No If yes, please explain briefly:

Have there been any injuries to the face or mouth? Yes No If yes, please explain briefly:
Has the child had any unfavorable dental experiences in the past?
Yes No Has the child ever sucked a thumb or fingers? Yes No Until what age:
Does the child have any speech problems? Yes No If yes, please explain briefly:
Is the child a mouth breather? Yes No While awake/asleep or both:
Does the child wake up with a dry mouth? Yes No
Has either parent had orthodontic treatment? Yes No List any musical instruments played:
MEDICAL HISTORY
Child's physician's and/or healer's name and address:
Is the child in good health? Yes No Does the child have any history of major illness? Yes No If yes, please explain briefly:
Has the child had any emergency hospitalizations in the past 5 years? Yes No If yes, please explain briefly:
Is the child under medical treatment at this time? Yes No If yes, please explain briefly:
List any allergies or drug sensitivity (ex. Penicillin, Amoxicillin, Erythromycin, Clindomycin, Local anesthesia, foods, or any over-the counter medications)
child taking any drugs or medications at this time? Yes No If yes, please list medications:

Does the child have a te	endency c	of getting:		
Colds	Yes	No		
Sore throats	Yes	No		
Ear infections	Yes	No		
Cold sore/canker sore	Yes	No		
Have tonsils and/or ade	noids bee	en remove	d? Yes	No
If yes, at what age:				
Does the child snore?	Yes	No		
Does the child have a hi	istory of	any of the	following:	
Asthma	Yes	No		
Rhuematic Fever	Yes	No		
Heart murmur	Yes	No	Type:	
Artificial heart valve	Yes	No		
Diabetes	Yes	No	Type:	
Hepatitis	Yes	No	Type:	
Hemophilia	Yes	No		
Tumors/growths	Yes	No		
Cancer	Yes	No	Type:	
Epilepsy	Yes	No		
AIDs or AIDs related co	mplex	Yes	No	
ADHD	Yes	No		
Fainting or dizziness	Yes	No		
If there are any other i	medical c	onditions	or health prob	lems that are not liste
above, please explain: _				
Signature:				
<u> </u>	(Parent	or Guardi	an)	