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

Health History - Child

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.

Yours in wellness,
Dr. Drewyer and Staff

Date:___/___/___

Name:_____
First 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 No
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? Yes No
Is there anything displeasing about the child's smile? Yes No
Have there been any injuries to the teeth (falls, blows, chips, etc.)?
Yes No If yes, please explain briefly:
_____
_____

more questions on the back>>>>>>>>>>>>>

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).
_____Is the child taking any drugs or medications at this time? Yes No
If yes, please list medications: _____
_____

Does the child have a tendency of getting:

Colds	Yes	No
Sore throats	Yes	No
Ear infections	Yes	No
Cold sore/canker sore	Yes	No

Have tonsils and/or adenoids been removed? Yes No

If yes, at what age:_____

Does the child snore? Yes No

Does the child have a history 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 complex	Yes	No	
ADHD	Yes	No	
Fainting or dizziness	Yes	No	

If there are **any** other medical conditions or health problems that are not listed above, please explain: _____

_____

_____

Signature:_____

(Parent or Guardian)