Child's History

These questions are of great value in aiding us in the treatment and better understanding of your child.

BLUEFISH DENTAL

Child's Name _____
Last First Initial Nickname

☐ Male ☐ Female Birthdate _____ Birthplace _____

Parent(s)/Guardian(s) Name _____

DENTAL INFORMATION:

Family Dentist _____ Phone No. _____

1. Is there a particular situation you would like examined today? ☐ Yes ☐ No If "yes" explain: _____

2. When was your child's last dental checkup and cleaning? _____

3. Has your child been seeing a dentist for regular checkups and care? ☐ Yes ☐ No

4. Has your child had any negative experiences with dentists or doctors? ☐ Yes ☐ No What, if any: _____

5. Taking Fluoride? ☐ Yes ☐ No

MEDICAL INFORMATION:

Child's Physician _____ Phone No. _____

1. Does your child have or has your child ever had any of the following:

	Yes	No
A) Heart disease, murmur o rheumatic fever? IF YES, antibiotic documentation will be required from patient's physician.	☐	☐
B) High or low blood pressure	☐	☐
C) Hay fever, sinus problems, or allergies	☐	☐
D) Herpes or cold sores	☐	☐
E) Diabetes	☐	☐
F) Emotional problems ☐ Autism	☐	☐
G) Kidney disease	☐	☐
H) Cancer, tumors, other growths	☐	☐
I) Radiation or chemotherapy	☐	☐
J) Reactions or allegies to any of the following: ☐ Aspirin or other pain medication ☐ Foods ☐ Latex ☐ Antibiotics ☐ Dental Anesthetics ☐ Other (food dye, flavorings, etc.)	☐	☐
K) Immunologic deficiency disease	☐	☐
L) Liver Disease (Hepatitis, Jaundice)	☐	☐
M) Thyroid problems	☐	☐
N) Lung disease (TB, asthma,, persistent cough, other)	☐	☐
O) Epilepsy, seizures, fainting spells	☐	☐
P) Arthritis	☐	☐
Q) Sore throats, tonsilitis,, earaches	☐	☐
R) Venereal disease	☐	☐
S) Abnormal bleeding or blood disorders If yes, what _____	☐	☐
T) Smoke or use other forms of tobacco	☐	☐
U) Any other major illness, surgery or conditions If yes, what _____	☐	☐
V) ADD or ADHD	☐	☐
W) Take any drugs or medications, prescription or non-prescription If yes, what _____	☐	☐
X) Is your child adopted? Does he/she know? ☐ Yes ☐ No	☐	☐
Y) Has your child been treated or currently being treated for any chaemical dependency?	☐	☐

Signed _____ Date _____