little smiles

HEALTH AND WELLNESS FORM

PATIENT NAME _____ **DATE** _____

1. ABOUT YOUR CHILD

Why is the child in the office today? _____

Child is currently having problems with the following:
(please check all that apply)

☐ Cavities
☐ Toothache
☐ Sensitive teeth
☐ Trauma
☐ Gum infection
☐ Color of teeth
☐ Tooth alignment
☐ Other _____

Please list the child's hobbies/interests? _____

_____

Why did you leave your previous dentist? _____

2. DENTAL HISTORY

On a scale of 1 to 5, with 5 being the highest rating:
(Please circle the number that best applies)

How important is the child's health to you?	1 2 3 4 5
How would you rate the child's current dental health?	1 2 3 4 5
Is the child's home water supply fluorinated?	☐ No ☐ Yes
Does a parent help brush the child's teeth daily?	☐ No ☐ Yes
Does the child brush his/her teeth daily with fluoride toothpaste?	☐ No ☐ Yes
Do you give the child any other form of fluoride?	☐ No ☐ Yes, _____
Does your child suck a finger, pacifier, or exhibit any other habits?	☐ Yes, please explain _____
Does the child grind his/her teeth?	☐ Yes, please explain _____
Has the child experienced problems with previous dental work?	☐ Yes, please explain _____
Is the child's mother or father afraid of dental care?	☐ Yes, please explain _____

3. MEDICAL HISTORY/ALLERGIES

DOES THE CHILD HAVE, OR HAS HAD, ANY OF THE FOLLOWING?

- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Cleft Palate/Lip
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Hay Fever
- ☐ Handicaps/Disabilities
- ☐ Hearing/Speech Difficulty
- ☐ Heart Murmur
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ HIV/AIDS Positive
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spinal Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Yellow Jaundice
- ☐ Other, unlisted

Please Explain _____

_____

IS THE CHILD ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Tree Nuts ☐ Other_____

Does your child have any learning disabilities, Autism, ADD or ADHD? ☐ Yes, please explain_____

Does your child have any social difficulties? ☐ Yes, please explain_____

Is the child under a physician's care now? ☐ Yes, please explain_____

Has the child ever been hospitalized or had a major operation? ☐ Yes, please explain_____

Has the child ever had a serious head or neck injury? ☐ Yes, please explain_____

Is the child on a special diet? ☐ Yes, please explain_____

Is the child taking any medications, pills, drugs, or vitamins? ☐ Yes, please explain_____

_____

Physician's Name_____

Phone # _____ Last Visit Date_____

Parent/Guardian Signature _____ Date_____