Children's Health Questionnaire

In an effort to make this dental visit a positive experience we ask that you complete the following questionnaire, as best you can, to help us get to know your child before their appointment.

Name: _____Date of Birth: _____

Parent(s)/ Guardian(s) Name(s): _____

Siblings (with ages): _____

Address: _____

Phone number: _____ (home) _____ (cell)

Physician: _____Pharmacy: _____

Regarding daytime care/schooling, is your child in:

Grade school ☐ **Home schooled** ☐ **Daycare** ☐ **At home** ☐

1. Is your child having any dental concerns or problems? If so, please explain:

2. Is this your child's first dental visit/experience? ☐ **Yes** ☐ **No**

3. If there have been previous experiences, have they been (circle one):

Positive? ☐ **Negative? *** ☐ **Successful?** ☐ **Unsuccessful? *** ☐ **N/A** ☐
*If there has been a negative/unsuccessful experience, please explain:

4. Has your child ever had:
   - Local Anesthesia (dental "freezing" or "numbing")? ☐ **Yes** ☐ **No**
   - Sedation? ☐ **Yes** ☐ **No**
   - General Anesthesia? ☐ **Yes** ☐ **No**

5. What is your child's regular dental hygiene routine? Brush? Floss? How often?

6. Do they brush on their own or assisted by parent/ guardian? ☐ **Own** ☐ **Assisted**

7. Does your child use a toothpaste containing Fluoride? ☐ **Yes** ☐ **No**

8. Please describe any medical issues/ disorders/ diseases or concerns your child currently has:

9. Please list any **allergies,** adverse reactions, or sensitivities to anything? ☐ **Yes** ☐ **No**
(e.g. penicillin, sulfa drugs, latex, metals, etc)

10. Please list any medications, supplements, or vitamins/minerals including prescription and non-prescription drugs? Include medication name, dose, frequency: ☐ **Yes** ☐ **No**

11. Please list any childhood illnesses or past medical experiences. ☐ **Yes** ☐ **No**
(include if they were positive or negative experiences)

12. Is there anything else you feel we should know about your child?

_____ _____

Parent/Guardian Signature Date