JAMES C. WEST, D.D.S., M.S.

Pediatric/Adolescent Dentist and Orthodontist

MEDICAL/DENTAL HEALTH QUESTIONNAIRE

We welcome you and your child into our practice and we will try to make his or her dental experience very pleasant. Please complete this form thoroughly. The information is necessary so we may properly aid and understand your child.

Child' Name _____ Nickname _____ Birthdate _____
(Last) (First) (Middle)

Parent's/Guardian's Name_____ Relationship to Child _____

Address _____ Gender ☐ Male ☐ Female
(Street) (City) (State) (Zip Code)

Physician or Pediatrician and Phone Number _____ _____

Child's Current Height_____ Child's Current Weight_____

Has your child had any history of, or conditions related to any of the following: [please check appropriate boxes]

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tuberculosis
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Rheumatic Fever	☐ Other
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex Allergy	☐ Seizures	
☐ Bleeding Disorder	☐ Diabetes	☐ Heart	☐ Liver	☐ Sickle Cell	
☐ Bone/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Snoring	

	YES	NO
1. Is our child in good health?	_____	_____
2. Is your child taking medicine now?	_____	_____
3. Is your child currently being treated for any illness?	_____	_____
4. Has your child had any unfavorable reaction or allergy to drugs, including antibiotics (Penicillin) and local anesthetic solution? If so, please specify. _____	_____	_____
5. Has your child had any history of thumbsucking, fingersucking, or did he or she use a pacifier past the age of 1-1/2 years?	_____	_____
6. Is your child still feeding on the bottle or breast? If no, at what age did this stop? _____	_____	_____
7. How would you describe your child's eating habits? _____	_____	_____
8. Has your child ever been hospitalized or had a surgical procedure? Please explain the reason for hospitalization, and when. _____	_____	_____
9. What surgical procedure was performed, and when. _____	_____	_____
10. Has your child ever had a blood transfusion?	_____	_____
11. Does your child bleed excessively when cut?	_____	_____
12. Does your child have or has he or she had in the past, frequent ear and throat infections or tubes in ears?	_____	_____
13. Has your child any history of hearing loss or speech problems? Underline and explain. _____	_____	_____
14. Has your child suffered any injuries to the head, mouth or teeth?	_____	_____
15, Have you ever been told or d you know your child is a mouth breather or he/she snores?		
16. Has your child had previous dental treatment? If so, when and where. _____	_____	_____
17 Has your child had any unfavorable experiences in a dental or medical office?	_____	_____
18. In your family is there any history of any malocclusions, bad bites, missing or extra teeth? Please underline and explain._____	_____	_____
19 . Was your child early, average or late getting his/her baby and/or permanent teeth? Please underline and explain._____	_____	_____
20. Has your child ever had a space maintainer, retainer, braces, orthodontic treatment or tooth movement? Please explain._____	_____	_____
21. How many times a day are your child's teeth brushed/ when? _____		
22 . What is our primary dental concern? _____		

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth have been answered to my satisfaction. I will not hold Dr. West, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I also authorize Dr. West and any other member of his staff to complete an oral examination, dental prophylaxis necessary radiographs and apply topical fluoride.

Parent's/Guardian's Signature _____ Date _____