ALABASTER SMILES
PEDIATRIC DENTISTRY

Lauri M. Williams, D.M.D., P.C.

CHILD'S MEDICAL HISTORY

THIS FORM NEEDS TO BE FILLED OUT YEARLY

CHILD'S NAME _____ **DOB** _____

1

Reason For Today's Visit: _____

Has your child ever been exposed to unpleasant dental or medical experiences: _____

Previous dental care – date and by whom: _____

Has your child had fluoridated tap water? _____ How Long: _____

Does your child take fluoride supplements? Yes _____ No _____

Has your child ever had any pain/tenderness in their jaw joint (TMJ / TMD)? Yes _____ No _____

Does your child brush his teeth daily? Yes _____ No _____ Floss his teeth daily? Yes _____ No _____

Child Physician: _____

Phone Number: _____ Date of last visit: _____

Is your child under medical care at present? Yes _____ No _____ Explain:_____

Please describe your child's current physical health: ( ) Good ( )Fair ( )Poor

Please list all drugs, supplements or holistic medicines your child is now taking : _____

_____

Please list all drugs or foods your child is allergic to and any other allergies: _____

_____

2

Does your child have any of the following habits?

Y	N	Thumb / Finger Sucking / Pacifier
Y	N	Lipsucking / Biting
Y	N	Nail Biting / Hair Chewing
Y	N	Nursing / Bottle
Y	N	Pureed Food

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3

Does your child have or ever had any of the following medical conditions?

Y N Heart Murmur _____ Y N Congenital Heart Defect _____

Y N Cancer-Past or Present _____ Y N Convulsions / Epilepsy _____

Y N Rheumatic Fever _____ Y N Abnormal Bleeding _____

Y N Hearing Impairment _____ Y N Hepatitis _____

Y N Asthma Triggers _____ Y N ADD/ADHD _____

Y N Kidney/Liver Problems_____ Y N HIV + / AIDS _____

Y N Tuberculosis _____ Y N Juvenile Arthritis _____

Y N Cystic Fibrosis _____ Y N Genetic Disorders _____

Y N Cerebral Palsy _____ Y N Stroke _____

Y N Handicaps/Disabilities _____ Y N Blindness or Visual Disturbance _____

Y N Diabetes-Oral Meds or Pump Injection _____

Y N Hemophilia, Sickle Cell Anemia or Other Bleeding Disorder _____

Y N Pregnant, if so how far along are you? _____

Y N Autism or Other Spectrum Disorders _____

Y N Tobacco Use, if so how often & what type? _____

Y N Alcohol Use, if so how often? _____

Y N Any Stays in Hospital _____

_____

Y N Any Operations / Surgery (Please Explain) _____

_____

_____

Y N Allergies to any drugs & what happen(s) _____

_____

Any Medical Conditions not mentioned above _____

_____

CONSENT: Because the patient is a minor, it is necessary for us to have consent of the parent or legal guardian prior to rendering dental treatment. Your signature below authorizes the doctors employed with Lauri M. Williams, DMD, PC to perform any dental treatment that your child may need.

Signature of Legal Guardian _____ Date _____