Smile Starters

General Dentistry for Youth

first tooth through age 20

Health History

Patient's Name: First _____ Last _____

Date of birth: Month _____ Day _____ Year _____

Dental History:

What brings you to the dental office today? _____

How long since the patient's last dental visit? ☐ 6 months ☐ more than 6 months ☐ more than a year ☐ never

Does the patient have any dental pain at this time? ☐ Yes ☐ No If yes, please explain _____

How often does the patient brush? ☐ once per day ☐ twice per day ☐ sometimes ☐ never

How often does the patient floss? ☐ once per day ☐ twice per day ☐ sometimes ☐ never

Does the patient have any of the following oral habits?

Suck their finger, thumb or pacifier ☐ Nail Biting ☐ Lip Sucking ☐ Biting ☐ Grinding ☐

Is the patient breast feeding? ☐ Yes ☐ No or still on the bottle? ☐ Yes ☐ No

Has the patient experienced a history of trauma or falls involving the face or teeth? ☐ Yes ☐ No If yes, please explain _____

Medical History:

	Yes	No
Is the patient under the care of a specialist now?	☐	☐
Has the patient ever been hospitalized or had a major operation?	☐	☐
Has the patient ever had a serious head or neck injury?	☐	☐
Is the patient on a special diet?	☐	☐
Does the patient use tobacco?	☐	☐
Does the patient use controlled substances?	☐	☐
Is the patient pregnant or trying to get pregnant? If yes, how many weeks?	☐	☐

When was the patient's last checkup with their physician? ☐ within a year ☐ more than a year ☐ never

List all medications, pills or drugs currently taken _____

Please mark the boxes below if the patient is allergic to any of the following:

Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal ☐ Sulfa ☐

Does the patient have any other allergies? Please list

_____

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Health History (Continued)

Does the patient have or have they ever had any of the following?

	Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Epilepsy or Seizures	☐	☐	Mental health care	☐	☐
AIDS/HIV Positive	☐	☐	Excessive Bleeding	☐	☐	Premature Birth	☐	☐
Anemia	☐	☐	Excessive thirst	☐	☐	Radiation Treatment	☐	☐
Artificial Heart Valve or Joint	☐	☐	Fainting Spells/Dizziness	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Growth Problems	☐	☐	Scarlet Fever	☐	☐
Autism/Spectrum disorder	☐	☐	Hay Fever	☐	☐	Sickle Cell Anemia or Trait	☐	☐
Birth Defects	☐	☐	Heart Attack/Failure	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Heart Trouble/Disease	☐	☐	Stomach Problems	☐	☐
Breathing Problem	☐	☐	Heart Surgery	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Hearing impaired	☐	☐	Thyroid or other gland disorder	☐	☐
Cancer	☐	☐	Hemophilia	☐	☐	Tonsillitis	☐	☐
Chemotherapy	☐	☐	Hepatitis A, B or C	☐	☐	Tuberculosis	☐	☐
Chest Pain/Angina	☐	☐	Herpes	☐	☐	Tumors or Growths	☐	☐
Cold Sores/Fever Blisters	☐	☐	High Blood Pressure	☐	☐	Ulcers	☐	☐
Congenital Heart Defect	☐	☐	Hives or Rash	☐	☐	Vision impaired	☐	☐
Developmental delay	☐	☐	Kidney Problems	☐	☐	Yellow Jaundice	☐	☐
Diabetes	☐	☐	Leukemia	☐	☐	Limitations in using arms or legs	☐	☐
Drug Addiction	☐	☐	Liver Disease/Problem	☐	☐	Other	☐	☐
Easily Winded	☐	☐	Low Blood Pressure	☐	☐			
Eating Disorder	☐	☐	Lung Disease	☐	☐			

Does the patient have any other medical condition not listed above?

Comments:

X_____

Signature of Parent/Legal Guardian