OKANAGAN SMILES

KIDS (12 and under)

Patient's Name: _____ Preferred Name: _____ Date of Birth:_____

Parent/Guardian's Name: _____ Relationship to Patient: _____

Please check all that apply:

☐ Anemia	☐ Chicken Pox	☐ Heart Problems	☐ Mononucleosis
☐ Arthritis	☐ Chronic Sinusitis	☐ Hepatitis	☐ Mumps
☐ Asthma	☐ Diabetes	☐ HIV/AIDS	☐ Rheumatic Fever
☐ Bladder Problems	☐ Ear Aches	☐ Immunizations	☐ Seizures
☐ Bleeding Disorders	☐ Epilepsy	☐ Kidney Problems	☐ Sickle Cell
☐ Bone/Joint Problems	☐ Fainting	☐ Latex Allergy	☐ Thyroid (Low/High)
☐ Cancer	☐ Growth Problems	☐ Liver Problems	☐ Tuberculosis (TB)
☐ Cerebral Palsy	☐ Hearing Problems	☐ Measles	☐ Other:_____

1. Is your child taking any prescription and/or over the counter medications or vitamin supplements? **Yes** **No**
If yes, please list: _____

2. Is your child allergic to any medications (ex. Penicillin, Antibiotics or other drugs)? **Yes** **No**
If yes, please list: _____

3. Is your child allergic to anything else, such as certain foods? **Yes** **No**
If yes, please list: _____

4. How would you describe your child's eating habits (ex. Types of foods, frequency)?
_____

5. Has your child ever had a serious illness? **Yes** **No**
If yes, please list: _____

6. Has your child ever been hospitalized? **Yes** **No**
If yes, please list the reason: _____

7. Does your child have a history of any other illnesses? **Yes** **No**
If yes, please list: _____

8. Does your child experience excessive bleeding when cut? **Yes** **No**

9. Is this your child's first dental visit? **Yes** **No**
If no, what was the date of the last dental visit? _____

10. Has your child had any problems with dental treatment in the past? **Yes** **No**

11. Has your child ever had dental radiographs (x-rays)? **Yes** **No**

12. Has your child ever suffered injuries to the mouth, head or teeth? **Yes** **No**

13. Has your child had any problems with the eruption or shedding of teeth? **Yes** **No**

14. Has your child had orthodontic treatment (ex. braces)? **Yes** **No**

15. Is fluoride toothpaste used? **Yes** **No**

16. What type of water does your child drink? **City water** **Well water** **Bottled water** **Filtered water**

17. How many times a day are your child's teeth brushed? _____ When are they brushed? _____

18. Do you still help your child to brush their teeth? **Yes** **No**

Parent/Guardian's Signature: _____ Date: _____

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