Fox Kids
DENTISTRY & ORTHODONTICS

# Patient Health History

Patient Name: _____ Nickname (if any): _____

Date of Birth: _____ Sex: M F

## Medical History

Patient's Pediatrician/Physician: _____ Last Well-Visit: _____

Practice Name: _____ Phone: _____

Current medications: _____

Allergies (food/drug/latex): _____

Has the patient ever had any of the following conditions?

| | | | | | |
|---|---|---|---|---|---|
| Asthma | Y | N | Congenital Birth Defects | Y | N |
| Abnormal Bleeding/Bruising | Y | N | Seizures/Epilepsy | Y | N |
| Sickle Cell Anemia | Y | N | Fainting spells | Y | N |
| Blood Disorders | Y | N | Neurological Problems | Y | N |
| High or low blood pressure | Y | N | Tuberculosis | Y | N |
| ADD/ADHD | Y | N | Physical Handicaps/Disabilities | Y | N |
| Autism | Y | N | Artificial Joints or Heart Valves | Y | N |
| Other Intellectual Disability | Y | N | Hearing Impairment | Y | N |
| Snoring/Sleep Apnea | Y | N | Congenital Heart Defect | Y | N |
| Tonsils/Adenoids removed | Y | N | Hepatitis/Liver Conditions | Y | N |
| Diabetes | Y | N | Kidney Problems | Y | N |
| Acid Reflux/GI Problems | Y | N | Organ transplant | Y | N |
| Eating Disorder | Y | N | HIV/AIDS | Y | N |
| Any Hospital Stays | Y | N | Immune Disorders | Y | N |
| Any Operations | Y | N | History of Infective Endocarditis | Y | N |
| Cancer | Y | N | Taken Bisphosphonate drugs | Y | N |

Does the patient smoke and/or chew tobacco? Y N

Female patients only:

Has menstruation begun? Y N If so, at what age? _____

Is the patient pregnant? Y N If so, when is due date? _____

Please elaborate on any of the above or list any other health problems/special concerns: _____

_____

_____

_____ (Continued on next page )

511 SW 10th Avenue, Suite 810 . Portland, OR 97205 . www.foxkidsdentistry.com
(503) 223-5039 office@foxkidsdentistry.com (503) 223-1123

Fox Kids
DENTISTRY & ORTHODONTICS

**Dental History**

Age of patient's first dental visit: _____ Date of last dental visit: _____

Previous Dentist/Office Name (if applicable): _____

How often does the patient:

Brush: _____ Floss: _____ Use Mouth rinse: _____

| | | | |
|---|---|---|---|
| Is the patient taking any supplemental fluoride? | Y | N | How much? _____ |
| Is your child currently experiencing any dental pain | Y | N | Explain: _____ |
| Have there been any injuries to the teeth, face, or mouth? | Y | N | Explain: _____ |
| Is the patient interested in braces or Invisalign? | Y | N | |
| Has your child been seen by an orthodontist previously? | Y | N | With whom: _____ |
| Has your child had his/her wisdom teeth removed? | Y | N | Date of removal: _____ |

Does the patient have any of the following habits:

| | | |
|---|---|---|
| Thumb/Finger Sucking | Y | N |
| Lip Sucking/Biting | Y | N |
| Pacifier Use | Y | N |
| Nail Biting | Y | N |
| Tongue thrust/lisp | Y | N |

Is there a history of:

| | | |
|---|---|---|
| Grinding teeth | Y | N |
| Clenching teeth | Y | N |
| Jaw joint clicking/popping | Y | N |
| Jaw joint pain/soreness | Y | N |

Additional comments regarding your child's dental history: _____

_____

_____

_____

I have read and understand the above questions, and have answered them to the best of my ability. If there are any changes to the patient's health status, I will inform the dentist and staff.

Parent/Guardian Signature: _____

Print name: _____

Relation to patient: _____ Date: _____

Doctor Signature: _____ Date: _____

511 SW 10th Avenue, Suite 810 . Portland, OR 97205 . www.foxkidsdentistry.com
(503) 223-5039 office@foxkidsdentistry.com (503) 223-1123