PATIENT HISTORY FORM

Date: .....

A. General Information

Patient's Legal First Name: ..... Legal Last Name: .....

Preferred Name: ..... Gender Identity: .....

Birth Date: ..... Personal Health Number: .....

Mailing Address: .....

	Parent/Guardian	Parent/Guardian
Name:		
Address (if different from above):		
Phone number	( ) Cell number: ( )	( ) Cell number: ( )
	Work number: ( ) ext:	Work number: ( ) ext:
Occupation:		
Email:		
Marital Status (of parents)	☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widow ☐ Common law	

Person responsible for account: ..... ❑ Other: .....

Purpose of visit: .....

Referred by: .....

B. Medical History *(Please check if your child has had any of the following)*

☐ Scarlet Fever	☐ HIV Positive	☐ Autism/ASD	☐ Vision Problems	☐ Blood Transfusion
☐ Rheumatic Fever	☐ Asthma	☐ Liver Disease	☐ Hearing Problems	☐ Meningitis
☐ Heart Murmur	☐ Lung Disease	☐ Blood Disorders	☐ Learning Disability	☐ Celiac
☐ Heart Disease	☐ Tuberculosis	☐ Bleeding Problems	☐ Epilepsy	☐ Bone Disorders
☐ Diabetes	☐ Convulsions	☐ Kidney Disease	☐ Skin Disease	☐ Snoring
☐ Hepatitis	☐ Cancer	☐ Premature Birth	☐ Eczema	☐ Mouth Breathing

☐ Emotional/behavioral disorders Please Specify: .....

☐ **Allergies** (Food, Medication) Please Specify: .....

☐ Other Please Specify: .....

Physician's Name: ..... Address: ..... Phone: .....

Does your child visit the Physician regularly: ..... Date of last visit: .....

Is your child taking any medication now: ☐ Yes ☐ No If Yes, please specify: .....

C. Preventive History

Has your child taken fluoride drops/tablets: .....

If Yes, When did he/she begin fluoride drops/tablets: .....

Is he/she currently taking fluoride supplements? ..... Amount? .....

(Please Turn Over)

Has your child ever lived in a fluoridated area: ..... Where? .....

When are your child's teeth brushed ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime

Who brushes the teeth ☐ Parent ☐ Child ☐ Other .....

Are your child's teeth flossed: ..... How often: .....

Which of the following applies to your child? *(Check if appropriate)*

☐ Snacks often ☐ Good eater at meals ☐ Eats or drinks before bedtime

☐ Needs a drink during the night - if yes what? .....

Does your child have any of the following more than 3 x /week *(Check if yes)*

☐ Peanut butter	☐ Cakes, pie, cookies	☐ Fruit juice	☐ Koolaid
☐ Candy	☐ Canned fruits	☐ Raisins	☐ Sugared cereals
☐ Soft drinks/pop	☐ Gum	☐ Ice cream	☐ Jams/jellies
☐ Sweetened vitamins			

Who prepares the food: .....

During infancy did your child have a pacifier: ..... Until what age: .....

During infancy did your child take a bottle in the crib: ..... Until what age: .....

What did the bottle contain: .....

Has your child had any of the following habits? Fingersucking? ..... Thumbsucking? ..... Until what age: .....

Other? .....

D. Behaviour History

How does your child respond at the Physician? .....

Has your child been hospitalized - if yes Where? .....

When? ..... Why? .....

How did your child respond at the hospital? .....

Has your child been to the dentist? ☐ Yes ☐ No Name of previous dentist: .....

When was last dental visit? ..... Reason for visit: .....

How did your child respond? .....

Has your child had any of the following treatment? *(Check if yes)*

☐ X-rays	☐ Local anesthetic (freezing)	☐ Extractions	☐ Orthodontics
☐ Fluoride treatment	☐ Restorative dentistry (fillings)	☐ General anesthesia	

How do you think your child will respond today? .....

Print Name: ..... Signature: .....

Date: .....

Thank You