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