the dentists
of owatonna family dentistry

Dr. Jeffrey Huxford • Dr. Nicholas Wiese • Dr. Bronson Schelling

Child Medical Hx

Patient Name: _____ Birth Date:_____ Date Created:_____

Parent Name: _____ Comment: _____

Name of parent/guardian whom this child lives with: _____ Comment: _____

Is your child taking any medications, pills or drugs? ☐ Yes ☐ No If yes: _____

Name of Physician: _____ Comment: _____

Date of last Physical: _____ Comment: _____

GENERAL HEALTH (please check)

☐ Excellent ☐ Good ☐ Fair ☐ Poor

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

HAS YOUR CHILD HAD ANY OF THE FOLLOWING?

Heart problems	☐ Yes	☐ No	Allergies to medicines/drugs	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Circulatory problems	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No	Nervous problems	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Measles	☐ Yes	☐ No	Radiation treatments	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Tonsilitis	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No

☐ Other? _____ Comment:_____

ORAL HYGIENE HABITS

Does your child brush daily? ☐ Yes ☐ No

How many times per day? _____

Does an adult assist with brushing? ☐ Yes ☐ No

How often does your child floss? _____

Does an adult assist with flossing? ☐ Yes ☐ No

DOES YOUR CHILD RECEIVE FLUORIDE IN ANY OF THE FOLLOWING FORMS?

Water Supply ☐ Yes ☐ No

Dentist ☐ Yes ☐ No

Toothpaste ☐ Yes ☐ No

Vitamins ☐ Yes ☐ No

Tablets/Drops ☐ Yes ☐ No

Other ☐ Yes ☐ No

Additional Comments:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____