Teen Health History

Name _____ Nickname _____ Birthdate_____Sex: M F

Address_____

Name of Physician & Clinic _____

Date of last medical exam _____ Reason for exam _____

Yes ( ) No ( ) 1. Does your teen have any health problems?

If yes, explain _____

Yes ( ) No ( ) 3. Is your teen taking any drugs or medications at this time?

If so, list _____

Yes ( ) No ( ) 4. Has your teen ever had any unfavorable reaction to foods, drugs/medicines?

If so, list _____

Yes ( ) No ( ) 5. Has your teen ever been hospitalized or injured? Date_____

Explain _____

Yes ( ) No ( ) 6. Does your teen have any limitations to sports activities?

If yes, explain _____

Does your teen have any of the following problems or diseases?

Yes ( ) No ( ) Breathing Disorders
Yes ( ) No ( ) Immuno-Suppressive disorders
Yes ( ) No ( ) Epilepsy/ Seizures
Yes ( ) No ( ) Hepatitis/ Liver disorders
Yes ( ) No ( ) ADD/Attention disorder
Yes ( ) No ( ) Congenital heart defects
Yes ( ) No ( ) Rheumatic fever
Yes ( ) No ( ) Excessive or prolonged bleeding
Yes ( ) No ( ) Other_____

Yes ( ) No ( ) Fainting spells
Yes ( ) No ( ) Jaundice
Yes ( ) No ( ) Tumors/ Cancer
Yes ( ) No ( ) Diabetes
Yes ( ) No ( ) Asthma
Yes ( ) No ( ) Allergies
Yes ( ) No ( ) Psychiatric care

Parent or Guardian Signature _____ Date _____

Teen Dental History

Name _____ Date of Birth _____

Yes ( ) No ( ) 1. Is this your child's first visit to the dentist?

If no, name of previous dentist? _____ Date of last visit_____

2. Has your child ever had any of the following?

Yes ( ) No ( ) A. Abcesses (Gum boils)
Yes ( ) No ( ) B. Toothaches
Yes ( ) No ( ) C. Injury to front teeth
Yes ( ) No ( ) D. Bleeding gums
Yes ( ) No ( ) E. Stained teeth
Yes ( ) No ( ) F. Cold sores (fever blisters)
Yes ( ) No ( ) G. Bad breath

3. Does (did) your child have habits that might affect oral health?

Yes ( ) No ( ) A. Clenching or grinding teeth
Yes ( ) No ( ) B. Finger or thumb sucking habits
Yes ( ) No ( ) C. Mouth breathing
Yes ( ) No ( ) D. Pacifier use
Yes ( ) No ( ) E. Pop or sugar beverage drinking

Yes ( ) No ( ) 4. Does your child have a speech problem?

Yes ( ) No ( ) 5. Is your water fluoridated at home?

Yes ( ) No ( ) 6. Are you on well water?

Yes ( ) No ( ) 7. Were any teeth (baby or permanent) removed by extraction?

A. Explain why _____
B. Was it suggested that the space be maintained? Yes ( ) No ( )

Yes ( ) No ( ) 8. Has your child had any unfavorable dental experience?

9. How many children are in your family? _____

I hereby authorize the administration of such medicines and performances of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Signature (Parent/ Guardian)_____ Date_____