PAUL L. PASTERNACK D.D.S., P.A.
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DENTISTRY FOR CHILDREN
Health Questionnaire

Child's Name _____ Age _____ Date of Birth _____

Whom May We Thank For Referring You _____ Male _____ Female _____

Name & Address of Physician (Routinely Visited) _____

Medical History - Please circle yes or no

Please indicate the names of your other children we treat:

_____

_____

_____

Is the child now in good health ..... Yes No

Is the child under the care of a physician ..... Yes No

Has the child had surgery ..... Yes No

Has the child had a history of:

Excessive Bleeding	Yes	No	Nervous Problem	Yes	No
Heart Trouble / Murmur	Yes	No	Fainting	Yes	No
Blood Pressure Problems	Yes	No	Dizziness	Yes	No
Asthma	Yes	No	Diabetes	Yes	No
Kidney Infection	Yes	No	Anemia	Yes	No
Rheumatic Fever	Yes	No	Tonsillitis	Yes	No
Ear Infections	Yes	No	Tuberculosis	Yes	No
Adenoidectomy or Tonsillectomy	Yes	No	Mumps	Yes	No
Measles	Yes	No	Chicken Pox	Yes	No

Has the child had a allergy to:

Antibiotics	Yes	No	Local Anesthetics	Yes	No

Other Allergies _____

Is the child receiving any medication ..... Yes No

Please describe any current medical treatment; including drugs, impending operations, recent injuries or other information the doctor should be aware of:

_____

_____

Dental History

Is this the child's first visit to the dentist ..... Yes No

Is the child worried ..... Yes No

Do you have fluoridated water in the home (or does the child take fluoride tablets) ..... Yes No

Have the child's teeth been treated with fluorides ..... Yes No

Have there been any injuries to the teeth ..... Yes No

If there was a previous dental experience ..... Yes No

How long since his/her last visit to the dentist _____

Was it satisfactory ..... Yes No

Were X-Rays taken ..... Yes No

Was a local anesthetic given ..... Yes No

Was there a history of dental decay ..... Yes No

Were any teeth removed by extraction ..... Yes No

Were there any special problems ..... Yes No

Does the child have a history of:

Thumb sucking (or finger)	Yes	No	Tongue Thrusting	Yes	No
Mouth Breathing	Yes	No	Nail Biting	Yes	No
Biting Hard Objects	Yes	No	What age did your child get off the bottle _____		
			What age was the pacifier discontinued _____		

How many times does the child brush his/her teeth each day? _____

Permission is hereby granted to the doctor to perform any necessary dental work for this child, after consulting with parent.

_____ _____

Signature Date

Name _____

Address _____

City, State, Zip _____

Telephone _____

Relationship: _____