Sandstone Dental
Perfecting One Smile at a Time

Child / Youth (ages 0 to 17 years)
Health History Questionnaire

For Office Use:

1. Patient Information

Last Name: ________________________ First Name: _______________________ DOB: _____ / _____ / _____ Gender: ______
day month year

Child's Address: _____________________________________ City: ____________ Province: _______ Postal Code: _________

Mother's Name (Guardian): _______________________________ Father's Name (Guardian): ______________________________

Resides with: Mother ❑ Father ❑ Both ❑ Preferred Contact: Mother ❑ Father ❑ Preferred Method of Contact: ______________

Mother's Contact: Home Phone: ______________________ Business: ______________________ Cell: _____________________

Father's Contact: Home Phone: ______________________ Business: ______________________ Cell: _____________________

Mother's Email: _______________________________________ Father's Email: ____

How did you hear about Sandstone Dental: ____

Family Doctor: _______________________________________ Phone Number: ____

Medical Specialist: ____________________________________ Phone Number: ____

Emergency Contact: ____________________________ Relationship: _________________ Phone Number: _________________

Your safety and optimal oral health are our priorities. The following information enables us to provide you with the best oral health care services safely and effectively. **Please complete this entire form.** During your visit you will be asked questions regarding your questionnaire responses. All information is confidential and treated in accordance with applicable provincial and federal privacy legislation.

What is the reason for your visit today?:

2. Dental Health

1. When was your child's last dental check up?	3. When were your child's last dental x-rays?
2. When was your child's last dental cleaning?	4. How often does your child brush? Floss?

Please check Yes or No for the following:	Yes	No		Yes	No
5. Do your child's gums bleed?			9. Does your child suffer frequent headaches?		
6. Has your child had orthodontic treatment/ braces?			10. Does your child have a removable dental appliance/device?		
7. Are your child's teeth sensitive to touch, temperature, or sweets?			11. Does your child have a dry mouth?		
8. Has your child ever had a head and / or neck injury?			12. Is your child nervous during dental treatment?		

Please Explain in Detail all Yes Answers:

3. Health History

1. When was your child's last medical visit? Reason:

Please check Yes or No for the following:	Yes	No		Yes	No
2. Has your child had any changes to their health or any medical treatment in the past year?			5. Has your child ever had a peculiar or adverse reaction to any medications or injections?		
3. Has your child ever been hospitalized for any illness or operation?			6. Does your child have any allergies or sensitivities?		
4. Has your child ever been advised to take antibiotics before dental treatment?			7. Female: Are you or could you be pregnant, or are you breastfeeding.		

Please Explain in Detail all Yes Answers

8. Please list all medications your child is taking, including prescription, over the counter, and natural health products		
Drug Name	Amount, Dose, Frequency	Reason

Does your child have or have they had any of the following?

Cardiovascular / Respiratory	Yes	No	Endocrine / Digestion	Yes	No
1. Angina / Coronary artery disease			1. Diabetes, what type?		
2. Heart valve problems or artificial heart valves			2. Thyroid / Parathyroid disease		
3. Congenital heart defects			3. Eating disorder		
4. Heart disease			4. Dietary restrictions		
5. Chest pain			Gastrointestinal / Urinary		
6. Heart attack			1. Hepatitis / Jaundice / Liver Disease		
7. Heart murmur			2. Acid reflux / Heart burn		
8. High or low blood pressure			3. Stomach ulcers		
9. Congestive heart failure			4. Kidney disease		
10. High or low cholesterol			Neurological / Muscular Skeletal		
11. Heart surgery / Transplant			1. Stroke		
12. Pacemaker			2. Seizure disorder / Epilepsy		
13. Rheumatic fever / heart disease / Infective endocarditis			3. Mental health disorder		
14. Shortness of breath			4. Arthritis / Rheumatoid arthritis		
15. Asthma			5. Osteoporosis		
16. Tuberculosis			6. Joint replacement		
17. Sinus problems			Other		
19. Chronic cough / new cough			1. Does your child use tobacco products?		
20. Emphysema / Chronic bronchitis			2. Does your child have a drug / alcohol dependency?		
21. Does your child snore?			3. Does your child have any vision or eye problems?		
22. Does your child have a sleeping disorder? (sleep apnea)			4. Has your child had any recent changes to their weight?		
Immune System / Infectious Diseases			Please explain in detail all Yes answers:		
1. HIV / AIDS					
2. Systemic lupus erythematous					
3. Other conditions that effect immune system (steroid therapy, Epstein bar, chemotherapy / radiation, cancer, sarcoidosis)					
4. Sexually transmitted infections (e.g. herpes)					

Do you have any other comments, questions, concerns or special needs that may affect your child's dental treatment?

By signing below, I agree all of the above information is correct to the best of my knowledge.

Parent / Guardian Signature: ______________________________ Date: ______________

Reviewed by (DDS): ______________________________ Date: ______________

Office Use Only:

Blood Pressure:	Pulse:	Sp02:	ASA: