



LA CROSSE PEDIATRIC DENTISTRY

Dr. Peter Frandsen

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DENTAL HISTORY (Please Circle)

PATIENT NAME: _____.

Has your child experienced any unfavorable dental care: YES NO

Ever had any pain associated with face, jaws, or teeth? YES NO

Ever had any teeth extracted? YES NO

Ever had any injury to teeth by bump, fall or otherwise? YES NO

Ever had dental x-rays? YES NO

Ever had swollen or bleeding gums? YES NO

Is your child taking any form of fluoride? YES NO

If YES, what form? _____

Ever had any of the following habits? (please circle) finger or thumb sucking, lip or nail biting, mouth breathing.

Does your child brush daily? YES NO Floss daily? YES NO

Do you assist your child in cleaning his/her teeth? YES NO

Do you desire 6 month cleanings, fillings and crowns as needed? YES NO

MEDICAL HISTORY OF PATIENT

Name of Physician _____

Name of Clinic _____ City _____

Last physical _____ Results _____

Is your child in good health? YES NO

Has your child ever been hospitalized? YES NO

If YES, for what reason _____

Is your child taking any medication? YES NO

If YES, the name of the medication and the reason _____

Is your child presently being treated by a physician? YES NO

If YES, for what reason? _____

Was your child's birth normal? YES NO

Does your child have any special medical or emotional needs? YES NO

If YES, please explain _____

Past surgical history? _____

Please circle if the patient has or has had any of the following conditions or diseases.

Anemia	Liver Involvement	Malignancies
Bleeding Disorders	Asthma	Lung problems
Rheumatic fever	Hay Fever	Brain injury
Heart Disease or Abnormality	Hepatitis	Whooping cough
Heart Murmur - Need Pre Med? Y or No	X-Ray therapy	Shunts
Heart Valve Replacement	Hearing problems	Joint Replacements
Diabetes	Mumps	Metal Rods or Screws placed
Epilepsy	Seizures	Positive HIV test
Speech problems	Tuberculosis	ADHD
Measles	Convulsions	Sensory Disorder
Chicken pox	Tumors	Autism
Kidney Involvement		

Is your child allergic to or had any unusual reaction to the following: (please circle)

Aspirin, Penicillin, Barbiturates, Ataractic drugs, dental local anesthetics,

Other allergies? Example: pets, food, environment, other _____

What specific information should I know about your child? _____

I acknowledge as this child's parent/guardian, that the above information is complete and true.

Signature _____ Date: _____

Relationship to Child _____