

Lawrence H. Schoonover, D.D.S.
P.O. Box 672 1 French St.
Clendenin, WV 25045
Phone 548-7227 965-7007

PEDIATRIC DENTISTRY

NAME _____
CHART NO. _____

CASE HISTORY

Health

- | | Yes | No | |
|---|--------------|---------------------|--------------|
| 1. Is your child being treated by your physician presently? | () | () | |
| 2. Has your child ever been a patient in a hospital? | () | () | |
| 3. Has your child ever been a patient in an emergency room? | () | () | |
| 4. Does your child have any allergies? | () | () | |
| 5. Is your child presently taking any medicines? | () | () | |
| 6. Does your child require immunizations presently to be protected against: | | | |
| Diphtheria, Whooping Cough and Tetanus | () | () | |
| Polio | () | () | |
| Measles and German Measles (Rubella). | () | () | |
| 7. Has your child had any difficulty in school? | () | () | |
| 8. Place a check if your child or any member of your family has (or had) problems with the following: | | | |
| Heart () | Diabetes () | Rheumatic fever () | Emotions () |
| Kidney () | Asthma () | Bleeding () | Other () |
| Liver () | Epilepsy () | Speech () | |

Dental

- | | Yes | No |
|--|----------------------|-------------------|
| 9. Has your child ever been seen by a dentist? | () | () |
| 10. Will your child be an uncooperative dental patient? | () | () |
| 11. Does any member of your family object to visiting the dentist? | () | () |
| 12. Has your child inherited any family dental characteristic? | () | () |
| 13. Does your child suck his fingers or thumb or have a similar habit? | () | () |
| 14. Please check if your child has (or had): | | |
| Toothache () | Teeth bumped () | Bleeding gums () |
| Sensitive Teeth () | Discolored Teeth () | Other () |
| 15. Is your community water supply fluoridated? | () | () |
| 16. Have you ever given your child fluoride vitamins or tablets? | () | () |
| 17. Do you supervise your child's cleaning procedures? | () | () |
| 18. Does your child use dental floss? | () | () |
| 19. How often does your child clean his teeth? | _____ | |
| 20. What type toothpaste does he use? | _____ | |
| Is there additional information we should be aware of prior to providing dental care for your child? _____ | | |

Comments: (All positive and/or significant responses must be elaborated by dentist)

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Dentist _____
(Name) (Number)

LAWRENCE H. SCHOONOVER, D.D.S.
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DATE: _____
DISCUSSION:

DENTAL HISTORY: (Investigate the following items)

Comments:

1. Regularity of dental visits
2. Regularity of oral prophylaxis
3. Previous gum treatment
4. Previous orthodontic treatment
5. Previous extractions
6. Previous root canal therapy
7. Reasons for teeth lost
8. Dental appliances worn by patient
9. Oral habits
10. Hereditary dental factors
11. Dietary aspects of oral health
12. Unusual dental experience

Completed by: _____