DENTISTRY FOR CHILDREN
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_____
Patient Name

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT

(to be completed by the patient)

Do you have any concerns about your mouth, teeth, or oral health? □NO □YES
_____

Have you recently experienced any dental/oral pain? □NO □YES
_____

Do you have any concerns with the appearance of your teeth or smile? □NO □YES
_____

Do you bleach your teeth? □NO □YES _____

Have there been any recent changes in your dietary habits? □NO □YES
_____

Are you taking any dietary or herbal supplements? □NO □YES
_____

Do you participate in sports or high speed activities (for example □NO □YES
_____ skiing, four-wheeling, motorcycling)?

We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.

Do you have any history of:

Oral habits (chewing fingernails, clenching/grinding teeth, etc.) □NO □YES □PREFER NOT TO ANSWER

Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.) □NO □YES □PREFER NOT TO ANSWER

Electronic cigarette (e-cig) use □NO □YES □PREFER NOT TO ANSWER

Eating disorder (anorexia, bulimia, etc.) □NO □YES □PREFER NOT TO ANSWER

Oral piercings/jewelry (including grill) □NO □YES □PREFER NOT TO ANSWER

Alcohol or recreational drug use/prescription abuse □NO □YES □PREFER NOT TO ANSWER

Inhalant use/abuse (such as huffing) □NO □YES □PREFER NOT TO ANSWER

Sexual activity (including oral sex) □NO □YES □PREFER NOT TO ANSWER

Abuse (physical, sexual, verbal, mental) □NO □YES □PREFER NOT TO ANSWER

Anxiety, depression, or feeling helpless/hopeless □NO □YES □PREFER NOT TO ANSWER

Females: Are you pregnant or possibly pregnant? □NO □YES

Is there anything you would like to discuss confidentially with your dentist? □NO □YES

Would you like to discuss a referral to a family dentist or general dentist because of your age? □NO □YES

_____ _____

Signature of parent Date