DEVON
PEDIATRIC DENTISTRY

Pediatric Medical/Dental History

Child's Full Name: _____ Nickname: _____

Date of Birth: ___ /___ /_____ Gender: ❑ M ❑ F

Height: _____ Weight: _____ Date of last physical examination: _____

Name/address/phone of primary physician:

_____

Name/address/phone of medical specialists:

_____

Is your child being treated by a physician at this time? Reason _____ ❑ Y ❑ N
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?
List name, dose, frequency, & date started: _____ ❑ Y ❑ N
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ❑ Y ❑ N
List date & describe: _____
Has your child ever had a reaction to or problem with an anesthetic? Describe _____ ❑ Y ❑ N
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medications?
List: _____ ❑ Y ❑ N
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List: _____ ❑ Y ❑ N
Is your child up to date on immunizations against childhood diseases? ❑ Y ❑ N

Please mark **"Y"** if your child has a history of the following conditions. For each **"Y",** provide details in the box at the bottom of this list. Mark **"N"** after each line if none of those conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions... ❑ Y ❑ N
Problems with physical growth or development... ❑ Y ❑ N
Sinusitis, chronic adenoid/tonsil infections... ❑ Y ❑ N
Sleep apnea/snoring, mouth breathing, or excessive gagging... ❑ Y ❑ N
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease... ❑ Y ❑ N
Irregular heart beat or high blood pressure... ❑ Y ❑ N
Asthma, reactive airway disease, wheezing, or breathing problems... ❑ Y ❑ N
Cystic fibrosis... ❑ Y ❑ N
Frequent colds or coughs, or pneumonia... ❑ Y ❑ N
Frequent exposure to tobacco smoke... ❑ Y ❑ N
Jaundice, hepatitis, or live problems... ❑ Y ❑ N
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems... ❑ Y ❑ N
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions... ❑ Y ❑ N
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder... ❑ Y ❑ N
Bladder of kidney problems... ❑ Y ❑ N
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems... ❑ Y ❑ N
Rash/hives, eczema or skin problems... ❑ Y ❑ N

Impaired vision, hearing, or speech..... ❑ Y ❑ N
Developmental disorders, learning problems/delays, or intellectual disability..... ❑ Y ❑ N
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures..... ❑ Y ❑ N
Autism/autism spectrum disorder..... ❑ Y ❑ N
Recurrent or frequent headaches/migraines, fainting, or dizziness..... ❑ Y ❑ N
Hydrocephaly or placement of shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)..... ❑ Y ❑ N
Attention deficit/hyperactivity disorder (ADD/ADHD)..... ❑ Y ❑ N
Behavioral, emotional, communication, or psychiatric problems/treatment..... ❑ Y ❑ N
Abuse (physical, psychological, emotional, or sexual) or neglect..... ❑ Y ❑ N
Diabetes, hyperglycemia, or hypoglycemia..... ❑ Y ❑ N
Precocious puberty or hormonal problems..... ❑ Y ❑ N
Thyroid or pituitary problems..... ❑ Y ❑ N
Anemia, sickle cell disease/trait, or blood disorder..... ❑ Y ❑ N
Hemophilia, bruising easily, or excessive bleeding..... ❑ Y ❑ N
Transfusions or receiving blood products..... ❑ Y ❑ N
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow, or organ transplant ..... ❑ Y ❑ N
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS..... ❑ Y ❑ N

PROVIDE DETAILS HERE:

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told?..... ❑ Y ❑ N
If yes, describe

What is your primary concern about your child's oral health? _____
How would you describe:

- your child's oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
- your oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
- the oral health of your other children? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Is there a family history of cavities?..... ❑ Y ❑ N
If yes, indicate all that apply: ❑ Mother ❑ Father ❑ Brother ❑ Sister
Does your child have a history of any of the following? For each "Y" response, please describe:

Inherited dental characteristics ❑ Y ❑ N _____
Mouth sores or fever blisters ❑ Y ❑ N _____
Bad breath ❑ Y ❑ N _____
Bleeding gums ❑ Y ❑ N _____
Cavities/decayed teeth ❑ Y ❑ N _____
Toothache ❑ Y ❑ N _____
Injury to teeth, mouth, or jaws ❑ Y ❑ N _____
Clinching/grinding his/her teeth ❑ Y ❑ N _____
Jaw joint problems (popping,etc.) ❑ Y ❑ N _____
Excessive gagging ❑ Y ❑ N _____

When did your child's first tooth erupt? _____
Sucking habit after one year of age……❑ Y ❑ N
If yes, which: ❑ Finger ❑ Thumb ❑ Pacifier ❑ Other ❑ For how long? _____
Is there a family history of missing or extra teeth?.....❑ Y ❑ N
Is there a family history of orthodontics?.....❑ Y ❑ N
How often does your child brush his/her teeth? _____ times per _____
Does anyone help your child brush?.....❑ Y ❑ N
How often does your child floss his/her teeth? ❑ Never ❑ Occasionally ❑ Daily
Does anyone help your child floss?.....❑ Y ❑ N
What type of toothbrush does your child use? ❑ Hard ❑ Medium ❑ Soft ❑ Electric ❑ Unsure
What toothpaste does your child use? _____
What is the source of your drinking water at home? ❑ City/community apply ❑ Private well ❑ Bottled water
Please check all sources of fluoride your child receives:
❑ Drinking water ❑ Toothpaste ❑ Over-the-counter rinse ❑ Prescription rinse/gel
❑ Prescription drops/tablets/vitamins ❑ Fluoride treatment in the dental office ❑ Fluoride varnish by pediatrican/other practitioner ❑ Other: _____
Does your child regularly eat 3 meals each day?.....❑ Y ❑ N
Is your child on a special or restricted diet?.....❑ Y ❑ N If "yes" describe: _____
Is your child a 'picky eater'?.....❑ Y ❑ N If "yes" describe: _____
Does your child have a diet high in sugars or starches?.....❑ Y ❑ N If "yes" describe: _____
Do you have any concerns regarding your child's weight? .....❑ Y ❑ N If "yes" describe: _____
How frequently does your child have the following?
Candy or other sweets ❑ Rarely ❑ 1-2 times/day ❑ 3 or more times/day Product: _____
Chewing gum ❑ Rarely ❑ 1-2 times/day ❑ 3 or more times/day Type: _____
Snacks between meals ❑ Rarely ❑ 1-2 times/day ❑ 3 or more times/day Usual snack: _____
Soft drinks* ❑ Rarely ❑ 1-2 times/day ❑ 3 or more times/day Product: _____
(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, energy drinks)
Please note other significant dietary habits: _____
Does your child participate in any sports or similar activities?.....❑ Y ❑ N
If yes, list: _____
Does your child wear a mouth guard during these activities?.....❑ Y ❑ N
Has your child been examined or treated by another dentist?.....❑ Y ❑ N
If yes - Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____
Were x-rays taken of the teeth or jaws? ❑ Y ❑ N Date of most recent dental x-rays: _____
Has your child ever had orthodontic treatment (braces, spacers, or other appliances)?..... ❑ Y ❑ N
If yes, when? _____
Has your child ever had a difficult dental appointment? ❑Y ❑ N If YES, describe: _____
How do you expect your child will respond to dental treatment? ❑ Very well ❑ Fairly well ❑ Somewhat poorly ❑ Very poorly
Is there anything else we should know before treating your child? ❑ Y ❑ N
If yes, describe: _____

Signature of parent/guardian: _____
Relationship to child: _____ Date: _____