



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 liver 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 or 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? _____

Does your child bottle or breast feed uninterrupted throughout the night?..... Y N

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 supply 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 pediatrician/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: _____

