Pediatric Medical History

Child's Full Name_____ Nickname_____ Date of Birth___/___/___
Address:_____ City_____ State_____ Zip_____
Mother's Name_____ Date of Birth_____ SS#_____ Driver's License#_____
Father's Name_____ Date of Birth_____ SS#_____ Driver's License#_____
Parent/Guardian's e-mail address_____ Phone Number_____
Who Brought patient today?_____ Relationship to patient_____
Patient Gender: Male Female Race/Ethnicity_____ Height_____ Weight_____ Date of last physical examination_____
Name/address/phone of primary physician:_____
Name/address/phone of medical specialist:_____

Is your child being treated by a physician at this time? Reason _____	Yes	No
Is your child taking any medication (prescription, or over-the-counter), vitamins, or dietary supplements? ----------	Yes	No
List name, dose, frequency 7 date started: _____		
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ----------	Yes	No
List date & describe:_____		
Has your child ever had a reaction to or problem with an anesthetic? Describe_____	Yes	No
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medications? List_____	Yes	No
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List_____	Yes	No
Is your child up to date on immunizations against childhood diseases?_____	Yes	No

Please circle YES if your child has a history of the following conditions. For each YES provide details in the box at the bottom of this list. Circle NO after each line if none of those conditions applies to your child.

Complications before or during birth, prematurity, birth defects,syndromes,or inherited conditions----------	Yes	No
Problems with physical growth or development----------	Yes	No
Sinusitis, chronic adenoid/tonsil infections----------	Yes	No
Sleep apnea/snoring, mouth breathing, or excessive gagging----------	Yes	No
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease----------	Yes	No
Irregular heart beat or high blood pressure----------	Yes	No
Asthma, reactive airway disease, wheezing, or breathing problems----------	Yes	No
Cystic fibrosis----------	Yes	No
Frequent colds or coughs, or pneumonia----------	Yes	No
Frequent exposure to tobacco smoke----------	Yes	No
Jaundice, hepatitis, or liver problems----------	Yes	No
Gastroesophageal/acid reflux disease(GERD), stomach ulcer, or intestinal problems----------	Yes	No
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions----------	Yes	No
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder----------	Yes	No
Bladder or kidney problems----------	Yes	No
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems----------	Yes	No
Rash/hive, eczema, or skin problem----------	Yes	No
Impaired vision, hearing, or speech----------	Yes	No
Developmental disorders, learning problems/delays, or intellectual disability----------	Yes	No
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures----------	Yes	No
Autism/autism spectrum disorder----------	Yes	No
Recurrent or frequent headaches/migraines,fainting, or dizziness----------	Yes	No
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous----------	Yes	No
Attention deficit/hyperactivity disorder (ADD/ADHD) ----------	Yes	No
Behavioral, emotional, communication, or psychiatric problems/treatment ----------	Yes	No
Abuse (physical, psychological, emotional, or sexual) or neglect ----------	Yes	No
Diabetes, hyperglycemia, or hypoglycemia ----------	Yes	No
Precocious puberty or hormone problems----------	Yes	No
Thyroid or pituitary problems ----------	Yes	No
Anemia, sickle cell disease/trait, or blood disorder ----------	Yes	No
Hemophilia, bruising easily, or excessive bleeding ----------	Yes	No
Transfusions or receiving blood products ----------	Yes	No
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant----------	Yes	No
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), Sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS----------	Yes	No

PROVIDE DETAILS HERE: _____

Is there any other significant medical history **pertaining to this child or his/her family** that the dentist should be told?---------- Yes No

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 Not applicable

Is there a family history of cavities? Yes NO If yes, indicate all that apply: Mother Father Brother Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics Yes No _____

Mouth sores or fever blisters Yes No _____

Bad breath Yes No _____

Bleeding gums Yes No _____

Cavities/decayed teeth Yes No _____

Toothache Yes No _____

Injury to teeth, mouth, or jaws Yes No _____

Clinching/grinding his/her teeth Yes No _____

Jaw joint problems (popping, etc.) Yes No _____

Excessive gagging Yes No _____

Sucking habit after 1 year of age Yes No If yes, which: Finger Thumb Pacifier Other For how long? _____

How often does your child brush his/her teeth _____times per_____ Does someone help your child brush? Yes NO

How often does your child floss his/her teeth? Never Occasionally Daily Does someone help your child floss? Yes No

What type of toothbrush does your child use? Hard Medium Soft Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? City/community supply Private well Bottled water

Do you use a water filter at home? Yes No If Yes, type of filtering system:_____

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? Yes No

Is your child on a special or restricted diet? Yes No If Yes, describe: _____

Is your child a 'picky eater'? Yes No If Yes, describe: _____

Does your child have a diet high in sugars or starches? Yes No If Yes, describe: _____

Do you have any concerns regarding your child's weight? Yes No 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, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities? Yes No If Yes, list: _____

Does your child ever wear a mouthguard during these activities? Yes No If yes, type: _____

Has your child been examined or treated by another dentist? Yes No

If Yes: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? Yes No Date of most recent dental x-rays: _____

Has your child ever had orthodontic treatment(braces, spacers, or other appliances)? Yes No If Yes, describe: _____

Has your child ever had a difficult dental appointment? Yes No 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? Yes NO

If Yes, describe: _____

_____

Our office performs fluoride treatments on patients as is deemed necessary; however, some insurance plans have strict guidelines on age and frequency allowances. Please check your preference:

_____Yes, I would like for my child to receive fluoride today if it is covered by my insurance.

_____Yes, I would like for my child to receive fluoride today even if it is not covered by my insurance and am prepared to cover the fee of $40.

_____No, I would not like for my child to receive fluoride today due to Financial reasons Personal reasons

_____ _____ _____ _____

Signature of parent/guardian Relationship to child Date Signature of staff member reviewing