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Pediatric Medical History

Child's Full Name: _____ **Nickname:** _____ **Date of birth:**____/____/____

Gender: ☐ M ☐F **Race/Ethnicity:** _____ **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_____ ☐YES ☐NO

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ……..... ☐YES ☐NO

List name, dose, frequency & 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 medication? 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 mark YES if your child has a history of the following conditions. For "Yes", provide details in the box at the bottom of this list. Mark no after each line if none of those conditions applies to you 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/hives, eczema or skin problems ……..... ☐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 hormonal 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 one 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 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, when? _____

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: _____

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

Thank you for taking the time to inform us of your child's health history