Pediatric Medical and Dental History

Patient Name_____Date_____Acct.#_____

Name Patient prefers to be called:_____ Date of Birth_____Sex:__M __F

Health problems and medications could have an important interrelationship with a patient's dental care. Please answer all of the following questions:

Does the child have, or has he/she ever had, or been treated for any of the following?

(Starred items may require premedication.)

ADD/ADHD	Y	N	Heart Disease	Y	N
AIDS/HIV positive	Y	N	*Heart Murmur	Y	N
Anemia	Y	N	Hepatitis, type_____	Y	N
Arthritis	Y	N	High Blood Pressure	Y	N
Asthma	Y	N	Kidney Problems	Y	N
Bulimia/Anorexia	Y	N	Liver Problems	Y	N
Cancer	Y	N	Mouth Ulcers	Y	N
Chemotherapy	Y	N	Radiation Treatment	Y	N
Cold Sores/Fever Blisters	Y	N	*Rheumatic Fever	Y	N
*Congenital Heart Disorder	Y	N	Sickle Cell Disease/Trait	Y	N
Developmental Delay	Y	N	Speech Problems	Y	N
Diabetes	Y	N	Stomach Problems	Y	N
Epilepsy/Seizures	Y	N	Stroke	Y	N
Excessive Bleeding	Y	N	Sinus Problems	Y	N
Fainting/Dizziness	Y	N	Tuberculosis	Y	N

Please list any other medical problems_____

_____

Child's physician(s)Name(s)_____

Address_____Phone_____

Has the child ever had a serious head or neck injury? Y N

If yes, please describe:_____

Has the child ever been hospitalized? Y N

If yes, please explain:_____

Is the child allergic to any medications, foods, or substances? Y N

If yes, please check or list: ___penicillin ____latex ____bananas ____red dye #40

___peanuts ____tree nuts Other:_____

Is the child taking any medications, pills, or drugs, including over-the-counter drugs? Y N

If yes, please give drug name, dosage, and frequency:_____

_____

I acknowledge that this information is correct and authorize a dental examination for this child including necessary radiographs, photographs, and acceptable methods to accomplish these services.

Signature of parent or guardian_____Relationship to patient_____

Reviewed and updated: (TO BE FILLED OUT *AT FUTURE APPOINTMENTS ONLY.)*

Initial_____date_____	Initial_____date_____	Initial_____date_____
Initial_____date_____	Initial_____date_____	Initial_____date_____
Initial_____date_____	Initial_____date_____	Initial_____date_____
Initial_____date_____	Initial_____date_____	Initial_____date_____

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Has the child been to a dentist before? Y N
If yes, please give dentist's name, address, and phone number:_____

Has the child been seen by the Dental Van? Y N when?_____

Does the child drink from a bottle? Y N
At bedtime? Y N
Does the child drink from a sippy cup? Y N
Other than at meals? Y N
What beverage? ___milk ___fruit juice (orange, apple, grape, etc.) ___sweet tea
___ soft drinks ___Kool-Aid ___water ___other_____
Does the child's drinking water come from ___city system ___private system ___deep well ___bottled
How often are the child's teeth brushed?_____ by whom?_____
What type toothpaste?_____
Does the child take a fluoride supplement? Y N
Does the child use a fluoride rinse? Y N
Are the child's teeth flossed? Y N by whom?_____
Do any of the child's teeth hurt? Y N which ones?_____
Does the child suck a pacifier? Y N
Does the child suck his thumb/fingers? Y N
Does the child suck his tongue? Y N

The following questions will help us get to know your child so we can help him/her feel comfortable in our office.

Father's Name_____ Mother's Name_____
Do both parents live in the home? Y N With whom does the child live?_____
Does the child attend school or daycare? Y N Where?_____
Does the child have brothers or sisters? Y N Please list:_____
Does the child have pets? Y N _____
What activities does the child enjoy?_____

Please add anything you believe is important for the dentist to know._____
_____
_____