

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 each "YES", provide details in the box at the bottom of this list. Mark 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 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Problems with physical growth or development | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sinusitis, chronic adenoid/tonsil infections | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sleep apnea/snoring, mouth breathing, or excessive gagging | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Irregular heart beat or high blood pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Does your child require prophylactic antibiotic prior to dental care? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Asthma, reactive airway disease, wheezing, or breathing problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cystic fibrosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent colds or coughs, or pneumonia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent exposure to tobacco smoke | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Jaundice, hepatitis, or liver problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bladder or kidney problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Rash/hives, eczema or skin problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Impaired vision, hearing, or speech | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Developmental disorders, learning problems/delays, or intellectual disability | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cerebral palsy, brain injury, epilepsy, or convulsions/seizures | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Autism/autism spectrum disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recurrent or frequent headaches/migraines, fainting, or dizziness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Attention deficit/hyperactivity disorder (ADD/ADHD) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Behavioral, emotional, communication, or psychiatric problems/treatment | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Abuse (physical, psychological, emotional, or sexual) or neglect | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes, hyperglycemia, or hypoglycemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Precocious puberty or hormonal problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Thyroid or pituitary problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Anemia, sickle cell disease/trait, or blood disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hemophilia, bruising easily, or excessive bleeding | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Transfusions or receiving blood products | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS | <input type="checkbox"/> YES | <input type="checkbox"/> 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 _____
Clinging/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/vital
 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 _____