# MEDICAL HISTORY

DATE:

*Please complete sections 1—10 regarding your child's medical and dental history.*

**1** Child's Pediatrician/Physician_____ Phone_____ Last Exam _____

**YES** ☐ **NO** ☐ Is your child currently being treated for any medical problems?

**YES** ☐ **NO** ☐ Is your child currently under the care of <u>any other</u> specialist provider? Provider Name(s) _____

**2** **MEDICATIONS:** List any prescription and over-the-counter medications your child is currently taking:

_____

_____

**3** **YES** ☐ **NO** ☐ Are <u>Immunizations</u> up to date?

**4** **YES** ☐ **NO** ☐ Any health conditions that require antibiotics or other medications prior to dental treatment?

**5** **ALLERGIES:** Has your child ever had an allergic reaction (hives, skin rash, itching, etc.) to:

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Local anesthetics |
| ☐ | ☐ | Penicillin/Amoxicillin |
| ☐ | ☐ | **Any other Allergies:** _____ |

**6** **HOSPITALIZATIONS/SURGERIES (including Dental surgery):**

| Reason | Date | Outcome/Problems |
|---|---|---|
| | | |
| | | |
| | | |

**7**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Development Delay |
| ☐ | ☐ | Autism Spectrum |
| ☐ | ☐ | ADHD/ADD |
| ☐ | ☐ | Anxiety |
| ☐ | ☐ | Eating Disorder |
| ☐ | ☐ | Seizures or Epilepsy |
| ☐ | ☐ | Fainting |
| ☐ | ☐ | Brain damage/head injury/concussion |
| ☐ | ☐ | Cerebral Palsy |
| ☐ | ☐ | Learning problems/delays |
| ☐ | ☐ | **<u>Any other Neurological/Psychological Disorder</u>** |
| ☐ | ☐ | Chronic Ear infections |
| ☐ | ☐ | Vision problems |
| ☐ | ☐ | Apnea/snoring |
| ☐ | ☐ | **<u>Any other problems with the Head, Ears, Eyes, Nose, Throat</u>** |
| ☐ | ☐ | Congenital Heart Disease or Defect |
| ☐ | ☐ | Heart murmur |
| ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | **<u>Any other Heart Disorder</u>** |
| ☐ | ☐ | Asthma/Reactive Airway Disease |
| ☐ | ☐ | Seasonal Allergies/Hay Fever |
| ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Cystic fibrosis |
| ☐ | ☐ | **<u>Any other Respiratory (Lung) Disorder</u>** |
| ☐ | ☐ | Urinary Tract or Bladder problems |
| ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | **<u>Any other Bladder or Kidney Disorder</u>** |

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Eczema |
| ☐ | ☐ | Limitation of use of arms or legs |
| ☐ | ☐ | **<u>Any other Skin or Musculoskeletal Disorder</u>** |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | Hormonal Problems |
| ☐ | ☐ | **<u>Any other Endocrine Disorder</u>** |
| ☐ | ☐ | Jaundice |
| ☐ | ☐ | Gastroesophageal/acid reflux disease |
| ☐ | ☐ | Ulcerative colitis/Crohn's Disease |
| ☐ | ☐ | Hepatitis |
| ☐ | ☐ | **<u>Any other Stomach, Intestinal or Liver Disorder</u>** |
| ☐ | ☐ | Anemia |
| ☐ | ☐ | Bleeding Problems |
| ☐ | ☐ | Hemophilia |
| ☐ | ☐ | Sickle cell disease/trait |
| ☐ | ☐ | Cancer, tumor, other malignancy |
| ☐ | ☐ | Immune Disorder |
| ☐ | ☐ | Chemotherapy/Radiation therapy/bone marrow transplant |
| ☐ | ☐ | **<u>Any other Blood (Hematologic/Lymphatic/Immunologic) Disorder</u>** |
| ☐ | ☐ | Cleft lip or palate |
| ☐ | ☐ | Premature birth |
| ☐ | ☐ | Nutritional deficiencies |
| ☐ | ☐ | **<u>Any other Medical Disorders</u>** |

Patient Name:_____ DOB:_____ Age:_____ Gender:_____

## DENTAL HISTORY

**8**

Is this your child's first dental visit? **YES** ☐ **NO** ☐

Date of last visit _____

Name of dentist _____

What treatment was done? _____

Were any Xrays taken? _____

Has your child had any orthodontic treatment? **YES** ☐ **NO** ☐

Orthodontist: _____

**9**

Has your child had any unhappy dental experiences? **YES** ☐ **NO** ☐

If yes, please explain_____

_____

Has either parent had tooth decay ? **YES** ☐ **NO** ☐

How would you best describe your child's attitude toward brushing?

☐ **Enthusiastic** ☐ **Mediocre** ☐ **Negative**

**10**

Does your child:

| **YES** | **NO** | **N/A** | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Sleep with a bottle of milk? |
| ☐ | ☐ | ☐ | Breastfeed at night? |
| ☐ | ☐ | ☐ | Eat more than 3 sugar-containing snacks or beverages per day (ex. juice, candy, fruit snacks, cookies, etc)? |
| ☐ | ☐ | ☐ | Drink carbonated beverages or sports drinks? |
| ☐ | ☐ | ☐ | Use a pacifier or suck his/her thumb or fingers? |
| ☐ | ☐ | ☐ | Bite his/her fingernails? |
| ☐ | ☐ | ☐ | Participate in any sports? **Sport: _____** |
| ☐ | ☐ | ☐ | Have any history of trauma affecting the face or teeth? |
| ☐ | ☐ | ☐ | Are you concerned about the alignment of your child's teeth? |
| ☐ | ☐ | ☐ | Do you have any concerns about tobacco use and/or substance abuse for your child? |
| ☐ | ☐ | ☐ | Do you have any concerns about recent nutritional or dietary changes for your child? |
| ☐ | ☐ | ☐ | Is your child pregnant or possibly pregnant? |

☐ ☐ Is your child in pain? **Please describe: _____**

☐ ☐ Does your child brush with fluoridated toothpaste?

Brushing frequency:_____ */day* Flossing frequency:_____*/day* By whom? **Parent Child Both**

Any other concerns?_____

_____

Patient Name:_____ DOB:_____ Age:_____ Gender:_____