MEDICAL HISTORY

Clear Form

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):**

☐ None

Reason Date Outcome/Problems

_____

_____

_____

7 **Does your child have any of the following medical conditions:**

☐ **My child has no known medical conditions**

- ☐ Developmental Delay
- ☐ Autism Spectrum
- ☐ ADHD/ADD
- ☐ Anxiety
- ☐ Eating Disorder
- ☐ Seizures or Epilepsy
- ☐ Fainting
- ☐ Brain damage/head injury/concussion
- ☐ Cerebral Palsy

- ☐ Chronic Ear infections
- ☐ Vision problems
- ☐ Apnea/snoring

- ☐ Congenital Heart Disease or Defect
- ☐ Heart murmur
- ☐ Rheumatic Fever

- ☐ Asthma/Reactive Airway Disease
- ☐ Seasonal Allergies/Hay Fever
- ☐ Tuberculosis
- ☐ Cystic fibrosis

- ☐ Urinary Tract or Bladder problems
- ☐ Kidney Disease

- ☐ Arthritis
- ☐ Eczema
- ☐ Limitation of use of arms or legs

- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Hormonal Problems

- ☐ Jaundice
- ☐ Gastroesophageal/acid reflux disease
- ☐ Ulcerative colitis/Crohn's Disease
- ☐ Hepatitis

- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Hemophilia
- ☐ Sickle cell disease/trait
- ☐ Cancer, tumor, other malignancy
- ☐ Immune Disorder
- ☐ Chemotherapy/Radiation therapy/bone marrow transplant

- ☐ Cleft lip or palate
- ☐ Premature birth
- ☐ Nutritional deficiencies

- ☐ **Other:**

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

Check all that apply - Does your child:

- ☐ 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:_____