PEDIATRIC MEDICAL HISTORY FORM

Email Address: _____ **Date**_____

HEALTH HISTORY FORM

Name: _____ Birth: _____ / _____/ _____ Age: _____ Sex: ❑M ❑F
First Middle Last

Address: _____City: _____State: _____ Zip Code: _____
P.O. Box or Mailing Address

SSN: _____ -_____ -_____ Home No: (_____) _____ Alt. No: (_____) _____

Emergency Contact: _____ Relationship: _____ Phone No: _____

How did you hear about our office? ❑Internet ❑ Saw Sign ❑ Mailer ❑Referred by: _____ ❑Other _____

Do you have any of the following diseases or problems:

Active Tuberculosis	**Yes No**	Cough that produces blood	**Yes No**
Persistent Cough greater than 3 weeks duration	**Yes No**	Been exposed to anyone with tuberculosis	**Yes No**

If you answer Yes to any of the 4 questions above, please stop and return this form to the receptionist.

Is your child under the care of a physician? ..... **Yes No**
Physician Name:_____ Phone No: (____)_____ Date of last Exam:_____
Address: _____
Is your child taking any medication?..... **Yes No**
Please list:_____
Has your child ever been hospitalized, had surgery, a significant injury, or been treated in an emergency department?..... **Yes No**
Please list date and describe:_____
Has your child ever had a reaction or problem with an anesthetic?..... **Yes No**
If Yes, please describe:_____
Is your child allergic to any antibiotic, sedative, or other medication?..... **Yes No**
If Yes, please describe:_____
Is your child allergic to latex, metal, food, acrylic, or dye?..... **Yes No**
If Yes, please describe:_____
Is your child up to date with their vaccinations?..... **Yes No**

Please mark YES or NO if your child had or currently has any of the following medical conditions

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions	**Yes No**
Physical or growth delay	**Yes No**
Sinusitis, chronic adenoid/tonsil infections	**Yes No**
Sleep apnea/snoring, mouth breathing, or excessive gag reflex	**Yes No**
Congenital heart defect/disease, heart murmur, rheumatic fever	**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 exposure to tobacco smoke	**Yes No**
Frequent colds, cough, or pneumonia	**Yes No**
Jaundice, hepatitis, or liver problems	**Yes No**
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or other intestinal problems	**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, psoriasis, or other skin problems.....	**Yes No**
Autoimmune disease.....	**Yes No**
Impaired vision, hearing, or speech.....	**Yes No**
Developmental disorder, learning problem/delay, or intellectual disability.....	**Yes No**

MED HX PG 2 CHILD'S NAME:_____

Cerebral palsy, brain injury, epilepsy, convulsions or seizures	**Yes No**
Autism/ autism spectrum disorder	**Yes No**
Attention deficit/hyperactivity disorder (ADD/ADHD)	**Yes No**
Behavior, emotional, communication, or psychiatric problems	**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 has received blood products	**Yes No**
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, bone marrow or organ transplant	**Yes No**
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmited disease (STD), or human immunodeficiency virus (HIV)	**Yes No**
Pregnancy: Is there a possibility you or your child may be pregnant? (Please inform staff so that we may accommodate you)	**Yes No**
Is there any other significant medical history pertaining to this child or his/her family that the dentist should know about? If yes, please describe:_____	**Yes No**

Pediatric Oral Health

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**

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 **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/teeth? ❑ **Never** ❑ **Occasionally** ❑ **Daily**
What type of toothbrush does your child use? ❑ **Hard** ❑ **Medium** ❑ **Soft** ❑ **Unsure**
What toothpaste does your child use? _____
What is the source of drinking water at home? ❑ **City/community supply** ❑ **Private well** ❑ **Bottled water**

MED HX PG 3 CHILD'S NAME:_____

Do you use a water filter at home? ❑ **Yes** ❑ **No**

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/starches? ❑ **Yes** ❑ **No** If Yes, describe: _____
Do you have concerns about your child's weight? ❑ **Yes** ❑ **No** If Yes, describe: _____

How frequently does your child have the following?

Candy or other sweets ❑ **Rarely** ❑ **1-2times/day** ❑ **3 or more times/day**
Chewing gum ❑ **Rarely** ❑ **1-2times/day** ❑ **3 or more times/day**
Snacks between meals ❑ **Rarely** ❑ **1-2times/day** ❑ **3 or more times/day**
Soft drinks* ❑ **Rarely** ❑ **1-2times/day** ❑ **3 or more times/day**
(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Does your child participate in sports or similar activities? ❑ **Yes** ❑ **No** If Yes, describe: _____
Does your child wear a mouthguard for these activities? ❑ **Yes** ❑ **No** If Yes, type: _____

Has your child been seen by another dentist? ❑ **Yes** ❑ **No**
If yes: Date of last visit:_____ Reason for visit:_____ Name of Dentist:_____
Were X-rays taken: ❑ **Yes** ❑ **No** Date of most recent X-rays:_____
Has your child ever had orthodontic treatment (braces, spacers, or other appliance)?
If yes, when:_____ __ Name of Orthodontist:_____

Has your child ever had a difficult dental appointment? ❑ **Yes** ❑ **No**
If yes, please describe:_____

How do you expect your child to respond to dental treatment? ❑ **Very well** ❑ **Fairly well** ❑ **Somewhat poorly** ❑ **Very Poorly**

Please list anything else we should know before treating your Child:

_____

_____

NOTE: Both Doctor and patient/guardian are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

_____ _____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN PRINTED NAME DATE

_____ _____
SIGNATURE OF DENTIST DATE