

Pediatric Medical History

Child's Name: _____ Nickname: _____ Date of birth: ____/____/____ Gender: ☐ M ☐ F
Address: _____ Phone: _____/_____
Name of Pediatrician: _____ Last Exam: ____/____/____

- 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 | ☐ YES ☐ NO |
| Problems with physical growth or development | ☐ YES ☐ NO |
| Sinusitis, chronic adenoid/tonsil infections | ☐ YES ☐ NO |
| Sleep apnea/snoring, mouth breathing, or excessive gagging | ☐ YES ☐ NO |
| Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease | ☐ 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 colds or coughs, or pneumonia | ☐ YES ☐ NO |
| Frequent exposure to tobacco smoke | ☐ YES ☐ NO |
| Jaundice, hepatitis, or liver problems | ☐ YES ☐ NO |
| Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems | ☐ YES ☐ NO |
| Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions | ☐ 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 or skin problems | ☐ YES ☐ NO |
| Impaired vision, hearing, or speech | ☐ YES ☐ NO |
| Developmental disorders, learning problems/delays, or intellectual disability | ☐ YES ☐ NO |
| Cerebral palsy, brain injury, epilepsy, or convulsions/seizures | ☐ YES ☐ NO |
| Autism/autism spectrum disorder | ☐ YES ☐ NO |
| Recurrent or frequent headaches/migraines, fainting, or dizziness | ☐ YES ☐ NO |
| Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) | ☐ YES ☐ NO |
| Attention deficit/hyperactivity disorder (ADD/ADHD) | ☐ YES ☐ NO |
| Behavioral, emotional, communication, or psychiatric problems/treatment | ☐ 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 receiving blood products | ☐ YES ☐ NO |
| Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant | ☐ YES ☐ NO |
| Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS | ☐ YES ☐ 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/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 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 _____

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER:

Was your child born prematurely? ☐ YES ☐ NO If YES, what week? _____

What was your child's birth weight? _____

How long was your child breast-fed? ☐ N/A ☐ less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

How long was your child bottle-fed? ☐ N/A ☐ less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

Do/did you feed your child infant formula? ☐ YES ☐ NO If YES, what type? (check one): ☐ Ready to use ☐ Powdered ☐ Liquid concentrate

Does/did your child sleep with a bottle? ☐ YES ☐ NO If YES, content of bottle? _____

Does/did your child use a no-spill training cup (sippy cup)? ☐ YES ☐ NO

Child's age (in months) when first tooth appeared in mouth _____

Has your child experienced any teething problems? ☐ YES ☐ NO

When did you begin brushing his/her teeth? ☐ N/A ☐ before age 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

When did you begin using toothpaste? ☐ N/A ☐ before age 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

Who is your child's primary care taker during the day? _____ during the evening? _____

Name/age of siblings at home: _____

Signature of parent/guardian

Relationship to child

Date

Signature of staff member reviewing history

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT (to be completed by the patient):

Do you have any concerns about your mouth, teeth, or oral health? ☐ YES ☐ NO If YES, describe: _____

Have you recently experienced any dental/oral pain? ☐ YES ☐ NO If YES, describe: _____

Do you have any concerns with the appearance of your teeth or smile? ☐ YES ☐ NO If YES, describe: _____

Do you bleach your teeth? ☐ YES ☐ NO If YES, how often: _____

Have there been any recent changes in your dietary habits? ☐ YES ☐ NO If YES, describe: _____

Are you taking any dietary or herbal supplements? ☐ YES ☐ NO If YES, describe: _____

Do you participate in contact sports or high speed sports (skiing, motorcycles)? ☐ YES ☐ NO If YES, describe: _____

We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.

Do you have any history of:

Oral habits (chewing fingernails, clenching/grinding teeth, etc.)	☐ YES	☐ NO	☐ PREFER NOT TO ANSWER
Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.)	☐ YES	☐ NO	☐ PREFER NOT TO ANSWER
Eating disorder (anorexia, bulimia, etc.)	☐ YES	☐ NO	☐ PREFER NOT TO ANSWER
Oral piercings/jewelry (including grill)	☐ YES	☐ NO	☐ PREFER NOT TO ANSWER
Alcohol or recreational drug use/prescription abuse	☐ YES	☐ NO	☐ PREFER NOT TO ANSWER
Inhalant use/abuse (such as huffing)	☐ YES	☐ NO	☐ PREFER NOT TO ANSWER
Sexual activity (including oral sex)	☐ YES	☐ NO	☐ PREFER NOT TO ANSWER

Females: Are you pregnant or possibly pregnant? ☐ YES ☐ NO

Is there anything you would like to discuss confidentially with your dentist? ☐ YES ☐ NO

Would you like to discuss a referral to a family dentist or general dentist because of your age? ☐ YES ☐ NO

Signature of patient

Date

Signature of staff member reviewing history