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 ..... ❑ 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? _____

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 toothpaste does your child use? _____

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