

Pediatric Medical History

Child's legal name: _____ Nickname: _____ Date of birth: ____/____/____
 Birth sex: M F Current gender identity: _____ Pronouns: _____ Race/Ethnicity: _____ Height: ____cm Weight: ____kg
 Name/age and relationship of others living in the household: _____
 Primary physician: _____ Address/phone: _____ Last visit: _____
 Medical specialists: _____ Address/phone: _____ Last visit: _____

- 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
 Is your child immunized against human papilloma virus (HPV)? 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 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Problems with physical growth or development | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sinusitis, chronic adenoid/tonsil infections | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sleep apnea/snoring, mouth breathing, or excessive gagging | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Irregular heart beat or high blood pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Asthma, reactive airway disease, wheezing, or breathing problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cystic fibrosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent colds or coughs, or pneumonia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent exposure to tobacco smoke | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Jaundice, hepatitis, or liver problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bladder or kidney problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Rash/hives, eczema, or skin problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Impaired vision, visual processing, hearing, or speech | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Developmental disorders, learning problems/delays, or intellectual disability | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cerebral palsy, brain injury, epilepsy, or convulsions/seizures | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Autism/autism spectrum disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recurrent or frequent headaches/migraines, fainting, or dizziness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Attention deficit/hyperactivity disorder (ADD/ADHD) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Behavioral, emotional, communication, or psychiatric problems/treatment | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Abuse (physical, psychological, emotional, or sexual) or neglect | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes, hyperglycemia, or hypoglycemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Precocious puberty or hormonal problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Thyroid or pituitary problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Anemia, sickle cell disease/trait, or blood disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hemophilia, bruising easily, or excessive bleeding | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Transfusions or receiving blood products | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS | <input type="checkbox"/> YES | <input type="checkbox"/> 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 _____
- 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 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?

- Snacks between meals Rarely 1-2 times/day 3 or more times/day Product _____
- Candy or other sweets Rarely 1-2 times/day 3 or more times/day Type _____
- Chewing gum 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

MEDICAL/DENTAL HISTORY UPDATE

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 had any illness, surgery, injury, allergic reaction, or medical emergency in the past year? YES NO

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

Have there recently been any significant changes/disruptions to your child's family, home, or school routines? YES NO

Describe: _____

What is your primary concern regarding your child's oral health? _____

Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? YES NO

Describe: _____

Has your child's diet changed significantly since his/her last dental visit? Describe: _____ YES NO

Has your child been treated by another dentist/dental professional since last visiting our office? Reason: _____ YES NO

Is there any other change in the child's medical, dental, or family history that the dentist should be told? YES NO

Describe: _____

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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: _____

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

For each YES response, please describe: _____

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

Have you recently experienced any dental/oral pain? NO YES _____

Do you have any concerns with the appearance of your teeth or smile? NO YES _____

Do you bleach your teeth? NO YES _____

Have there been any recent changes in your dietary habits? NO YES _____

Are you taking any dietary or herbal supplements? NO YES _____

Do you participate in sports or high speed activities (for example skiing, four-wheeling, motorcycling)? NO YES _____

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.) NO YES PREFER NOT TO ANSWER

Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.) NO YES PREFER NOT TO ANSWER

Electronic cigarette (e-cig) use NO YES PREFER NOT TO ANSWER

Eating disorder (anorexia, bulimia, etc.) NO YES PREFER NOT TO ANSWER

Oral piercings/jewelry (including grill) NO YES PREFER NOT TO ANSWER

Alcohol or recreational drug use/prescription abuse NO YES PREFER NOT TO ANSWER

Inhalant use/abuse (such as huffing) NO YES PREFER NOT TO ANSWER

Sexual activity (including oral sex) NO YES PREFER NOT TO ANSWER

Abuse (physical, sexual, verbal, mental) NO YES PREFER NOT TO ANSWER

Anxiety, depression, or feeling helpless/hopeless NO YES PREFER NOT TO ANSWER

Females: Are you pregnant or possibly pregnant? NO YES

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

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

Signature of patient Date Signature of staff member reviewing history