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 ❑ 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
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis ❑ YES ❑ NO
Rash/hives, eczema, or skin problems ❑ YES ❑ NO

Impaired vision, visual processing, 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, or 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 _____

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: _____

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)

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