

**PEDIATRIC MEDICAL & DENTAL HISTORY (Under 18)**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_

Height\_\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_

MEDICAL HISTORY

Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Physical:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Has there been any change in the patient’s general health within the last year? \_\_\_\_\_Y \_\_\_\_N
* Is the patient now under the care of a physician (other than routine check up?) If so, what is being treated?\_\_\_\_\_Y\_\_\_\_\_\_N

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* Has the patient had a serious illness/ hospitalization in the past 5 years? If so, what for?

\_\_\_Y\_\_\_\_N

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |  |
| --- | --- | --- |
| ALLERGIES OR DRUG REACTIONS TO: | |  |
| \* Latex | \* Penicillin or other antibiotics | \* Sulfa drugs |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |
| \* Aspirin, Ibuprofen, Tylenol \* Local Anesthetic | | \* Codeine |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |
| \* Flouride | \* Nuts, Milk, Fruit | \* Red Dye |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |
| \* Other | \* Chlorhexidine |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |

IF Yes , Please

list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

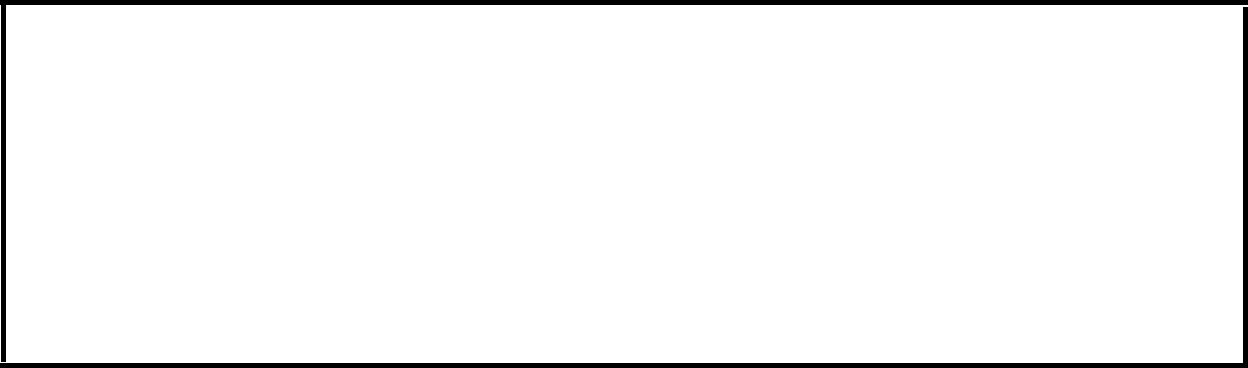
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PLEASE SELECT **YES** IF THE PATIENT HAS HAD ANY OF THE CONDITIONS LISTED BELOW, EITHER NOW OR IN THE PAST. CANNOT BE BLANK

|  |  |  |  |
| --- | --- | --- | --- |
| \* Heart Murmur | \* Damaged or artificial heart | \*Congenital Heart defect |  |
| Y\_\_\_\_N\_\_\_\_ | valve | Y\_\_\_\_N\_\_\_\_ |  |
| Y\_\_\_\_N\_\_\_\_ |  |

|  |  |  |  |
| --- | --- | --- | --- |
| \* Heart Disease | \* Rheumatic Fever | \* Heart Attack/Stroke |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |
| \* Angina | \* Liver Disease/Jaundice/ | \* Kidney disease |  |
| \* | Hepatitis Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |
| Y\_\_\_\_N\_\_\_\_ |  |
| \* Bleeding Disorder | \* Prolonged Bleeding | \* Arthritis/Joint problems |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |
| \* Prosthetic Joints | \* Bone fractures | \* Growth Problems |  |
| Y\_\_\_\_N\_\_\_\_ | \*Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_\_N\_\_\_\_ |  |
| \*Asthma | \* Sinus Problems | \* Respiratory Problems |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |
| \* Pneumonia | \* Cancer | \* Radiation Treatment |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |
| \* Epilepsy/ Seizures | \* Seasonal Allergies | \* Persistent Cough |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |
| \* Thyroid Problems | \*Stomach problems/GERD | \* Skin Disorder |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |
| \* Chronic Ear infections \* Hearing impairment | | \*Eye problems |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |
| \* Chronic fatigue/ | \* Tobacco, Drug or Alcohol use \* Frequent Headaches | |  |
| sleep disorder |  |  |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |
| \*Diagnosed with ADD, \* Treated for emotional | | \* Bed Wetting |  |
| ADHD or Hyperactivity problems | |  |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |
| \* Jaw or Face Trauma | \* Tonsils or Adenoids removed \* Growth Problems | |  |
| Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ | Y\_\_\_\_N\_\_\_\_ |  |

IF ANY OF THE ABOVE MEDICAL QUESTIONS WERE ANSWERED ‘YES”, PLEASE EXPLAIN:



To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental oﬃce of any changes in the patient’s medical status.

Signature of Parent or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



DENTAL HISTORY

Previous Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of most recent Dental exam?\_\_\_\_\_\_\_\_\_\_

Date of most recent Dental X-rays?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your Immediate Dental Concern?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PLEASE SELECY **YES** IF THE PATIENT HAS ANY OF THE CONDITIONS LISTED BELOW EITHER NOW OR IN THE PAST?

\* Discomfort from teeth or gums?

\* Bad taste/mouth odor?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Chipped or Broken teeth?

\* Root canal(s)/ Pulpotomy?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Food traps between teeth?

\* Pain in Jaw?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Missing teeth?

\*Teeth Extracted?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Injury to Face or Jaw?

\*Abnormal swallowing (tongue thrust)?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Frequent Headaches?

\* Snores during sleep?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\*Grind/Clinch teeth (awake or asleep)?

\* Have a tongue tie?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Bite problem?(underbite, overbite, crossbite)? \* Thumb sucking, lip/nail biting?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Frequent sore throats?

\* Clicking or popping jaw?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Speech problems/therapy?

\* Mouth breathing?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Have wisdom teeth been removed?

Frequently chews gum?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Have had a Flouride treatment before?

\* Have had numerous fillings before?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

\* Patient brushes teeth daily?

\* Patient flosses teeth daily?

Y\_\_\_\_N\_\_\_\_

Y\_\_\_\_N\_\_\_\_

Patient has had an Orthodontic Consultation or treatment?

Y\_\_\_\_N\_\_\_\_ If Yes, please give Orthodontist name and phone #:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his staﬀ responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

Signature of Parent or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_