

# 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 .....   | <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 |
| Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems .....   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Rash/hives, eczema or skin problems .....  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Impaired vision, 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, 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?

- 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 \_\_\_\_\_

### 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):**

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