Pediatric Dentistry Health History Dental History

Patient Name _____ Nickname _____ Age _____

Date of Birth _____ Sex M or F School _____ Grade _____

Chief reason for your child's visit to the Pediatric Dentist today? _____

_____

Medical History

Patient's Physician _____ Address _____ Phone _____

Date of your child's last physical examination? _____ Explanation:

1. Is your child being treated by a physician at this time? Y N _____
2. Is your child current on immunizations? Y N _____
3. Has your child had any significant injuries? Y N _____
4. Does your child have a history of any frequent infections? Y N _____
5. Is your child currently on any type of medication? Y N Drug?_____Dose?_____
6. Has your child ever been hospitalized? Y N _____
7. Office policy is to take X-rays only when they are indicated. Do we have your permission to take the necessary X-rays today? Y N
8. If your child has ever been diagnosed with any of the following, or has a history with any of the following, please circle and write a brief description or explanation, and let us know if they are currently followed by health care providers.

Anemia
Allergy _____
Asthma / Breathing / Lung
AIDS-HIV
Bleeding Abnormalities
Blood Transfusions Date _____
Behavior / Learning Problems
Brain Injury
Cancer / Tumor
Cerebral Palsy
Chicken Pox
Cleft Palate
Congenital Birth Defects
Convulsions / Seizures / Epilepsy
Diabetes / Endocrine Problems
Diphtheria
Drug Reactions (Adverse)
Emotional Distress
Eye / Vision Problems
Fainting / Headaches
Gastro-Intestinal Disease
Hearing Loss / Speech Therapy
Heart Disease
Hepatitis / Liver Disease
Kidney Disease
Measles
Mental / Physical Retardation
Mumps
Polio
Rheumatic Fever
Scarlet Fever
Syndrome _____
Tonsils / Adenoids

Explanation: _____

Are there any other significant problems that we need to address? _____

Dental History

Has your child ever been seen by a Dentist? Y N

Name of previous Dentist _____ Address _____ Phone _____

Date of last dental examination _____ Have x-rays been taken? Y N Date of last x-rays _____

Do we have your permission to call your previous dentist and have copies of your x-rays sent to us? Y N

Does your child have a history of sucking his/her thumb, fingers, or pacifier? Y N

Has your child been raised with fluoride in the drinking water? Y N

Has your child had fluoride supplements? Y N

Do you have any questions or concerns regarding your child's nutritional needs or fluoride needs? Y N

Has your child had any history of TMJ (jaw joint) pain or trauma? Y N

Are your child's teeth brushed two times a day? Y N Do you help? Y N

At what age did your child stop bottle / breast feeding? (circle) 6 months 12 months 18 months still feeding other _____

How do you expect your child to react in the dental chair? Very well Moderately well Moderately poor Very poor

Is there anything special that we can do to make this experience more pleasant and helpful?

Responsible Party

To the best of my knowledge; all of the preceding answers are true and correct. If my child ever has a change in his/her health or his/her medicines change, I will inform the doctor at the next appointment WITHOUT FAIL.

Parent's Signature: _____ Date _____