Patient's Medical / Dental History

Patient's Name_____ Nick Name_____ Date_____

Birth Date_____ Sex_____ Place of Birth (City, State) _____

Parent/Responsible Party Home Phone _____ Work Phone_____

Name of School, Day Care or Babysitter_____ Grade_____

Favorite toy or pastime_____

Name and address of child's previous dentist_____ Phone_____

Last dental exam_____ Last dental XRAY_____

Name of child's physician or pediatrician_____ Phone_____

Last physical exam_____ Referred by_____

Chief Complaint/reason for visit_____

General condition of child's health: _____

Has your child ever had *(Check if yes):*

- ❒ Heart trouble/Rheumatic Fever
- ❒ Breathing/Lung Asthma
- ❒ Liver/Hepatitis/GI Problems
- ❒ Kidney Problems
- ❒ Endocrine system
- ❒ Neurological Problems
- ❒ Enlarged tonsils
- ❒ Seizures
- ❒ Bleeding disorder
- ❒ Tuberculosis
- ❒ Tumors/Cancer/HIV
- ❒ Skin disorders
- ❒ Diabetes
- ❒ Snoring/Sleep apnea
- ❒ Mental Developmental Delays
- ❒ Behavior/Learning Problems
- ❒ Physical Developmental Delays
- ❒ Congenital Birth Defects
- ❒ Significant Injuries
- ❒ Ear infections
- ❒ Other

Explain: _____

Has your child ever had any allergies or adverse reactions to latex, antibiotics, food, medication or other substances?

❒ Yes ❒ No Explain_____

Has your child ever had any hearing, sight, coordination or special schooling problems?

❒ Yes ❒ No Explain_____

Please indicate any health problems not discussed above_____

Has your child ever been hospitalized? ❒ Yes ❒ No Date_____

Explain_____

Has your child ever needed psychological and/or psychiatric care?

❒ Yes ❒ No Explain_____

Has your child ever had any kind of surgery? ❒ Yes ❒ No Date_____

Has your child ever had tonsils removed or tonsillectomy? ❒ Yes ❒ No Date_____

Has your child ever had an history of abnormal bleeding?

❒ Yes ❒ No Explain_____

Has your child received any blood transfusions? ❒ Yes ❒ No

Is your child under a prescribed medication? ❒ Yes ❒ No

Please list names and dosages_____

Does any member of the family have any medical/dental problems?

❒ Yes ❒ No Explain_____

Was your child ❒ bottle-fed or ❒ breast-fed? For how long (months, years) _____

Was the term of pregnancy and birth of your child normal? ❒ Yes ❒ No

Please explain any complication including premature birth or low birth weight _____

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What do you think of the condition of your child's mouth?_____

Is this your child's first dental visit? ❒ Yes ❒ No

Has your child had any bad medical or dental experience? ❒ Yes ❒ No Explain: _____

Has your child had any previous dental treatment? ❒ Yes ❒ No

Type of treatment_____

Outcome? _____

How would you describe your child's personality & temperament?_____

How do you expect your child to react to his/her visit today?_____

Does any member of the family have any unusual dental problems or TMJ disorders?

❒ Yes ❒ No Explain_____

Child's habits? ❒ Finger sucking ❒ Tongue Thrusting ❒ Mouth Breathing ❒ Teeth Grinding ❒ Pacifier

❒ Other: Explain_____

At what age did first tooth appear? ❒ Early ❒ Late ❒ Normal

Did your child receive frequent medication while an infant? ❒ Yes ❒ No

What type? _____

Does your child receive fluoride in any of the following forms? ❒ Yes ❒ No

❒ Vitamins ❒ City Water ❒ Toothpaste ❒ Tablets/Drops(_____mg/day) ❒ Rinse/gel

How long has your child been on systemic fluoride? (Prescription)_____

Has your child ever had any injuries to his/her teeth, mouth, head or jaws?

❒ Yes ❒ No Explain_____

Has your child had a history of jaw clicking/popping/tenderness while opening or closing his/her mouth?

❒ Yes ❒ No Explain_____

Are you concerned about any special dental problems now?

❒ Yes ❒ No Explain_____

Is your child experiencing any dental pain or discomfort now?

❒ Yes ❒ No Explain_____

Please list any questions that you would like to have answered_____

_____

Name and birth dates of other children_____

_____

Signature of Parent or Guardian_____**Date**_____

For Office Use Summary of Medical History