Pediatric Medical History

Child's legal name:_____ Nickname: _____ Date of birth:___ / ___ / _____

Birth sex: ☐ M ☐F Current gender identity_____ Race/ethnicity_____

Primary physician_____ Telephone: _____ Last visit_____

Address: _____

Medical specialist _____ Telephone: _____ Last visit_____

Address: _____

Has your child been treated by a physician in the last 6 months?Reason _____ ☐Yes ☐ No

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ☐Yes ☐No

If Yes, 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

If Yes, 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 section at the bottom of this list. Mark NO after each line if none

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 heartbeat 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, 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 for "yes" answers: _____

_____

_____

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 _____

Adapted from "Pediatric Medical History" from the American Academy of Pediatric Dentistry, 2019.

Dental History

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

Is there a family history of cavities? ☐Yes ☐No. If Yes, indicate all that apply ☐Father ☐Mother ☐Siblings

Does your child have history of any of the following? For each "Yes" response, please describe:

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, moth or jaws	☐Yes	☐No	_____
Clinching/grinding his/her teeth	☐Yes	☐No	_____
Jaw joint problems (popping)	☐Yes	☐No	_____
Excessive gagging	☐Yes	☐No	_____

Sucking habit after one year of age ☐Yes ☐No If yes, which:☐Bottle ☐Thumb ☐Pacifier ☐Other For how long? _____

How often does your child brush his/her teeth? ____ times per day how long? _____(min).Does someone help your child brush? ☐Yes ☐No

How often does your child floss his/her teeth? ☐Never ☐Occasionally ☐ Daily Does someone help floss? ☐Yes ☐No

What type of toothbrush does your child use? ☐Hard ☐Medium ☐Soft ☐Not sure

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 ☐Fluoride rinse ☐Prescription drops/tablets ☐Fluoride treatment in dental office ☐Fluoride varnish by pediatrician ☐Other

Does your child regularly eat 3 meals each day? ☐Yes ☐No

Is your child on a special or restricted diet? If YES, describe _____ ☐Yes ☐No

Is your child a 'picky eater'? If YES, describe _____ ☐Yes ☐No

Does your child have a diet high in sugars or starches? ☐Yes ☐No

Do you have any concerns regarding your child's weight? If YES, describe: _____ ☐Yes ☐No

How frequently does your child have the following?

Candy or other sweets	☐Rarely	☐1 o 2 times/day	☐3 or more times/day
Chewing gum	☐Rarely	☐1 o 2 times/day	☐3 or more times/day
Snacks between meals	☐Rarely	☐1 o 2 times/day	☐3 or more times/day
Soft drinks*	☐Rarely	☐1 o 2 times/day	☐3 or more times/day

(* 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? List_____ ☐Yes ☐No

Does your child wear a mouthguard during these activities? ☐Yes ☐No

Has your child been examined or treated by another dentist? ☐Yes ☐No

If YES, 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

Has your child ever had a difficult dental appointment? If Yes, when _____ ☐Yes ☐No

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 / legal guardian_____ Relationship to patient_____ Date _____

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