Medical History Patient Name_____Birthdate:_____

Name of Pediatrician:_____Address:_____

_____Phone #:_____Date Last visit:_____

Is Child being treated by Physician currently? ___Yes ___No. If yes, Reason?_____

Drug Name	Dose	Dose/Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Childs allergies, unusual reactions (Anesthetics, Antibiotics, latex, food allergies) below:

_____

Does your Child have any Diseases/Conditions listed below? (✓all that apply)

GERD	Nutritional deficiencies	Dietary Restrictions/Eating Disorder
Autism	Bladder/Kidney Problems	Muscle/Bone/Joint Problems
Diabetes	Eczema/Skin Problems	Vision/Hearing/Speech Problems
Transfusions	VP/VA/VV shunt	Frequent Headaches/Fainting
HIV/AIDS/STD	Thyroid/Pituitary Problems	Cerebral Palsy/Seizure disorder
Liver Problems	Abuse physical/Emotional	ADD/ADHD/Behavior/Psychiatric issues
Cystic Fibrosis	Asthma/Lung Problem	Chronic Sinus/Adenoid/Tonsil infection
Rheumatic	Sleep Apnea/Snoring	Anemia/Blood disorders
Cancer	Frequent Cough/Cold	Congenital Heart Defect
Scarlett Fever	Frequent exposure tobacco	Birth defects/syndrome
Mouth Breathing	Inherited Conditions	High BP/Arrhythmia
Mononucleosis	TB, CMV/MRSA	Other (Explain):_____

Explain:_____

Describe other injuries, medical conditions, Drugs, pending surgeries, recent injuries, so dentist can evaluate relevance to dental treatment:

_____

MEDICAL HISTORY UPDATE: Since last visit to our office has anything changed ___Y___N

Explain:_____

_____

Parent/Guardian signature/date attesting above information_____date_____

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Dental History Patient Name_____Birthdate_____

Reason for Todays dental Visit:_____

Is this 1st visit to dentist: __Y___N. If No, Last visit MM_____ YY____Last dental x-ray:___MM___YY

Previous Dentist Name:_____Address:_____

Does child brush on own? _____Y/N. If no, do you Brush your child's teeth?_____Y/N.

How often_____ Toothbrush: Soft_____Hard_____Medium

Does child Floss on own? _____Y/N. If no, do you Floss your child's teeth?_____Y/N.

Does/did your child use a no-spill training cup (sippy cup)? Yes No

Source of drinking water: ____bottled_____city/community_____private well

Fluoride Source: Drinking Water__ Fluoride/multivitamin tabs___ Toothpaste___Mouth rinse___

Topical dental application___ If yes, How/who_____

Rate oral health (1-excellent, 2 Good, 3 Fair, 4 Poor): Child_____ Yours_____ Siblings_____
Has child had previous Unpleasant Dental Experience? ___Y____N. Describe:_____
Rate Childs expected response to dental treatment today? (1-excellent, 2 Good, 3 Fair, 4 Poor)_____ List
Childs Dental health concerns you have:

Child's Eating habits (✓all that apply):

3 meals/day Picky eater High sugar/starch diet weight issues
#/day: Candy/sweets_____ Chew gum____ Snack between meals____ Soft drinks___

Does your Child have any of below (circle or ☐next to it):

Bad Breath Bleeding Gums Mouth sores Fever Blisters Cavities
Toothache Clinching/Grinding teeth Gagging Inherited dental condition

Jaw/Joint Problems (clicking, popping, crunching noise while chewing)?_____

Tooth injury (If Yes, describe when, which, how)_____

Treatments to injured teeth_____

Does/Did your child do following and if stopped write age when stopped in blank line (if applicable):

Y__N__Use a Pacifier_____ Y__N__Thumb/finger sucking_____ Y__N__Tongue Thrusting_____
Y__N__Grind Teeth_____ Y__N__Mouth Breathing_____ Y__N__Lip sucking/biting_____
Y N -Bottle to bed_____. If yes, during Night___Nap____ What was in bottle?_____

Does your child play contact sport? ___Y___N. If yes, wears Mouthguard?___Y___N
Has your child had Orthodontic Treatment?_____Y_____N.
If yes, wears Braces, spaces, other dental appliances?___Y___N. IF yes, when?_____

Teenagers (14yr+) & Adolescent patients only:
Do you have concerns with appearance of your teeth or smile?_____Y_____N
Do you bleach your teeth? ____Y___N. If yes, what product?_____

Parent/Guardian signature/date attesting above information_____Date_____