

**Medical and Dental History**

**PERSONAL**

Child’s Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nickname (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_ Place of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings names and ages?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is your child adopted? Yes No If yes, does your child know? Yes No

Child’s pediatrician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What school does your child attend?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you think your child will act toward the dentist?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of today’s dental visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICAL**

**Has child ever had any of the following? (Please circle either YES or NO)**

Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No

ADD/ADHD Yes / No

AIDS (HIV) Yes / No

Anemia/Blood Problems Yes / No

Arthritis Yes / No

Asthma Yes / No

Autism Yes / No

Bed Wetting Yes / No

Bleeding Problems Yes / No

Cerebral Palsy Yes / No

Chicken Pox Yes / No

Cleft Lip / Palate Yes / No

Cold Sores/Herpes Yes / No

Diabetes Yes / No

Down’s syndrome Yes / No

Emotional Problems Yes / No

Eye Problems Yes / No

Hearing Problems Yes / No

Heart Murmur Yes / No

Heart Problems Yes / No

Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No

Yes / No

Hepatitis A, B, or C Yes / No

High Blood Pressure Yes / No

Hyperactivity Yes / No

Kidney Problems Yes / No

Learning Disability Yes / No

Liver Problems Yes / No

Measles/ Mumps Yes / No

Intellectually Disabled Yes / No

Mitral Valve Prolapse Yes / No

Psychiatric Yes / No

Physical Handicap Yes / No

Rheumatic Fever Yes / No

Speech Problems Yes / No

Seizures/Epilepsy Yes / No

Sickle Cell Problems Yes / No

Thyroid Problems Yes / No

Tongue Thrust Yes / No

Tuberculosis Yes / No

Tumor/Cancer Yes / No

Yellow Jaundice Yes / No

Please list any specific diagnosis; diseases, syndromes, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please discuss problems further, if necessary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics? Y / N

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is your child currently taking any medications? Y/ N Please List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been hospitalized? Y/ N

If yes when and what for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is your child taking any supplemental fluoride? Y/ N

Does your child have any breathing problems? Y /N

Breathes primarily through **nose** or **mouth**? (Please circle)

Does your child snore? Y/ N

**HABITS**

Does your child have any of the following habits?

Thumb or finger sucking Y/ N Pacifier use Y/ N Nail biting Y/ N Lip sucking or biting Y/ N

Biting hard objects Y/ N Tooth grinding Y/ N

Did your child use a bottle? Y/ N If yes, when did they stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child currently nurse? Y/ N

If your child is still nursing/using a bottle, how often throughout the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the bottle used at night? Y/ N What do you put in the bottle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY DENTAL HISTORY** *(Circle appropriate parent, if yes)*

Has Mother or Father had a lot of cavities? Y / N Has Mother or Father had orthodontic care? Y / N

Does Mother or Father have periodontal disease? Y / N

Does Mother or Father have TMJ (Jaw Joint) problems? Y / N

**CHILD’S DENTAL HISTORY**

Has your child seen a pediatric dentist before? Y / N

When and Where was your child’s last dental visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any unfavorable experiences in a dental or medical office? Y / N

Does your child have any dental problems presently? Y / N

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does your child brush his/her teeth per day? \_\_\_\_\_\_\_\_\_\_\_\_\_ Do you help? Y / N Sometimes

How often does your child floss? \_\_\_\_\_\_\_\_\_\_\_\_\_ Do you floss your child’s teeth? Y / N Sometimes

**To the best of my knowledge the above questions have been accurately answered.**

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_