Child's name: _____

Primary Physician: _____

Phone: _____ Last Visit: _____

Medical specialist: _____

Phone: _____ Last Visit: _____

Is your child being treated by a physician at this time? ☐ YES ☐ NO If YES, explain the reason:_____

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

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

List date & describe:_____

_____

Has your child ever had a reaction to or problem with anesthetic?

☐ YES ☐ NO

Describe: _____

Is your child allergic to latex or anything else such as metals, acrylic or dye?

☐ YES ☐ NO

List: _____

Is your child up to date on immunizations against childhood diseases?

☐ YES ☐ NO

Has your child ever had a reaction or allergy to antibiotic, sedative or other medications? ☐ YES ☐ NO

List: _____

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

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 heart beat 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

Gastro esophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ☐ YES ☐ NO

Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions ☐ YES ☐ NO

Abuse (physical, psychological, emotional, sexual or neglect) ☐ 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 disorder, 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, depression, sensory issues ☐ YES ☐ NO

Diabetes, hyperglycemia, or hypoglycemia ☐ YES ☐ NO

Precocious puberty or hormonal problems ☐ YES ☐ NO

Thyroid or pituitary problem ☐ YES ☐ NO

Transfusions or receiving blood products ☐ YES ☐ NO

Anemia, sickle cell disease/trait, or blood disorder ☐ YES ☐ NO

Hemophilia, bruising easily, or excessive bleeding ☐ YES ☐ NO

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? ☐ 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

☐ YES ☐ NO

Provide details here: _____

_____

_____

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: _____

_____

For each YES response, please describe:

Inherited dental characteristics ☐ YES ☐ NO _____

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, mouth or jaw ☐ YES ☐ NO _____

Jaw joint problems (popping, etc.) ☐ YES ☐ NO _____

Sucking habit after one year of age ☐ YES ☐ NO If yes, which: ☐ Finger ☐ Thumb ☐ Pacifier ☐ Other For how long? _____

How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? ☐ YES ☐ NO

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

Please check all sources of fluoride your child receives:

☐ Drinking water ☐ Toothpaste ☐ Over-the-counter rinse ☐ Prescription rinse/gel ☐ Prescription drops/tablets/vitamins

☐ Fluoride treatment in the dental office ☐ Fluoride varnish by pediatrician/other practitioner ☐ Other: _____

Is your child on a special or restricted diet? ☐ YES ☐ NO Please describe: _____

How frequently does your child have the following? Juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks _____

Has your child been examined or treated by another dentist? ☐ YES ☐ NO

If yes, Date of first visit: _____ Date of last visit: _____ Reason for visit: _____

Were xrays taken of the teeth or jaws? ☐ YES ☐ NO Date of most recent dental xrays?: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ☐ YES ☐ NO If yes, when? _____

Has your child ever had a difficult dental appointment? ☐ YES ☐ NO If YES, describe: _____

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 child Date