Pediatric Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Is the child under a physician's care now? Name of child's physician.	◯ Yes ◯ No	If yes
Has the child ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Is your child on a special diet?	◯ Yes ◯ No	If yes
Does your child have any allergies to food or drugs? Please list.	◯ Yes ◯ No	If yes
Does your child need to be premedicated befor dental treatment? Please explain.	◯ Yes ◯ No	If yes
Are the child's immunizations current?	◯ Yes ◯ No	

Dental Questions

Does the child have any of the following habits?

Lip sucking/biting	◯ Yes ◯ No	Nursing bottle habits	◯ Yes ◯ No	Thumb/finger sucking	◯ Yes ◯ No
Was the child breast fed?	◯ Yes ◯ No	Nail biting	◯ Yes ◯ No		

Does the child brush his/her teeth daily?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No
Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Swelling of Limbs	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Cystic Fibrosis	◯ Yes ◯ No						

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes
Has the child been to the dentist before? Please list dentist and date of last visit.	◯ Yes ◯ No	If yes
Why did you bring the child to the dentist today?	◯ Yes ◯ No	If yes
Has the child ever had a serious or difficult problem associated with previous dental work?	◯ Yes ◯ No	If yes
Has the child ever had any pain or tenderness in his/her jaw joint (TMJ)?	◯ Yes ◯ No	If yes
Is the child's water fluoridated? If not are they taking flouridated suppliments?	◯ Yes ◯ No	If yes

Social History

Does child attend school? Where?	◯ Yes ◯ No	If yes
Please list any special interest, sports or hobbies.	◯ Yes ◯ No	If yes
Are there other siblings seen by us?	◯ Yes ◯ No	If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Parent or Guardian:

X Date:_____