

Although dentistry deals with primarily teeth and its surrounding structures, oral cavity is a part of the entire body. Health problems that your child may have, or medications that the child may be taking could have an important interaction with dentistry your child will receive. Thank you for answering the following questions thoroughly.

Patient's Name \_\_\_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Male Female

### Medical History

- Yes No Any problems/complications during pregnancy/delivery? \_\_\_\_\_
- Yes No Does your Child have any health problems? \_\_\_\_\_
- Yes No Has your child been diagnosed with any medical conditions? \_\_\_\_\_
- Yes No Has your child ever been hospitalized? (For & When) \_\_\_\_\_
- Yes No Has your child ever had surgery? (For & When) \_\_\_\_\_
- Yes No Is your child taking any medications? (List) \_\_\_\_\_
- Yes No Is your child allergic to any medication /food/latex? (List) \_\_\_\_\_
- Yes No Is your child's immunization up to date? \_\_\_\_\_
- Name and number of your child's physician \_\_\_\_\_

### Check any of the following conditions for which the patient has been treated:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV Positive    | <input type="checkbox"/> Down syndrome        | <input type="checkbox"/> Leukemia             |
| <input type="checkbox"/> ADHD/ADD             | <input type="checkbox"/> Ear Infection        | <input type="checkbox"/> Nutritional Bleeding |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Emotional Problems   | <input type="checkbox"/> Prolonged Bleeding   |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Endocrine Problems   | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Autism/ASD/Aspergers | <input type="checkbox"/> Epilepsy/ Seizures   | <input type="checkbox"/> Speech Problems      |
| <input type="checkbox"/> Blood Problems       | <input type="checkbox"/> Eye Problems         | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Hearing Problems     | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Thyroid Disease      |
| <input type="checkbox"/> Cerebral Palsy       | <input type="checkbox"/> Hepatitis A/B/C      |   |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Liver/Kidney Disease |   |

### Dental History

- Main reason for today's visit? \_\_\_\_\_
- How often are the child's teeth brushed?  1x/day  2x/day  every other day  Not regularly
- How often are the child's teeth being flossed?  1x/day  every other day  1x/week  Not regularly
- Who does the brushing/flossing?  Parent  Child  Half & Half  None
- Fluoride use:  Rx by MD/DMD  In H2O  Toothpaste  Fluoride Rinse  None
- When was the child weaned off nursing/bottle?  6 month  12 months  24 months  Still use
- Does the child have any oral habits?  Thumb/finger  Binky  Mouth breather  Grinding
- History of dental trauma: Yes No If yes please explain: \_\_\_\_\_
- How would you rate the mother's oral health?  Excellent  Good  Fair  Poor  Don't know
- How would you rate the father's oral health?  Excellent  Good  Fair  Poor  Don't know
- How would you rate child's sugar consumption? (candy, juice, etc.)  Low  Average  High

Is there any additional medical/dental information that you may want your dentist to know?

Parent/Guardian Signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_