

# Patient Medical History



## GENERAL

Child's Name: \_\_\_\_\_

Describe the primary concern with your child's teeth: \_\_\_\_\_

Has your child had any unfavorable reactions to past dental treatment?

If so, please explain: \_\_\_\_\_

What things does your child enjoy?: \_\_\_\_\_

## DENTAL

Does/Is your Child:

- Yes       No      Take Fluoride Supplements
- Yes       No      Use a pacifier, suck thumb/finger/lip, bite lip If so, please circle answer
- Yes       No      Bite or chew nails
- Yes       No      Grind teeth/clench Jaws/have TMJ pain? If so, please circle answer
- Yes       No      Gag easily
- Yes       No      Brush daily If so, how often? \_\_\_\_\_ Floss daily?  Yes  No If so, how often? \_\_\_\_\_
- Yes       No      Breastfed Age discontinued \_\_\_\_\_
- Yes       No      Bottledfed Age discontinued \_\_\_\_\_
- Yes       No      Require Antibiotics for dental work?
- Yes       No      Need dental work completed (referred from another dentist or you feel they do)
- Yes       No      Presently in dental pain?
- Yes       No      Have any extra, missing, or extracted teeth? If so, please circle answer
- Yes       No      Have a history/present today with trauma to the head, face, or teeth? which one?
- Yes       No      Have any other habits not listed above? If yes please specify \_\_\_\_\_

## MEDICAL

Please check any problems or conditions that may apply to your child & circle exact answer

- Asthma/Respiratory problems     Epilepsy/Seizures     Mental Disorder
- Autism/ADD/ADHD     Endocrine     Rheumatic Fever
- Brain Injury     Gastrointestinal/Kidney     Speech Delay
- Bleeding disorder/Delay/Anemia     Heart Murmur     Transfusion
- Cancer     Hepatitis/Liver/Infectious Dis     Tuberculosis
- Cerebral Palsy/CNS problem     Herpes/Fever Blisters     Vision Disorder
- Congenital Heart Defect/Problem     Immunizations up to date     My child is healthy
- Diabetes     Lung Problems     Developmental Delay
- Drug/Alcohol Abuse
- Other: \_\_\_\_\_

If you said yes to any of the above, please explain: \_\_\_\_\_

Current medications & dosages taken: \_\_\_\_\_

Allergies or adverse reactions to any medications (e.g. penicillin/sulfas) \_\_\_\_\_

Allergies to any substances (e.g. latex) \_\_\_\_\_

Previous hospitalizations, surgeries, or serious illnesses, and date \_\_\_\_\_

Has your child had any abnormal bleeding associated with previous extractions, surgery, or trauma? (If yes, please explain) \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Previous Dentist \_\_\_\_\_

Child's Pediatrician: \_\_\_\_\_ Phone Number \_\_\_\_\_

Is there anything else you would like us to be aware of regarding your child? \_\_\_\_\_

Authorization and Release To the best of my knowledge, the question on this form have been accurately answered.

I understand that providing incorrect information can put my child's health at risk and that it is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and /or other health practitioners as necessary. May we request release of your child's medical and dental records? \_\_\_\_\_

With your verbal permission, you agree to release your child's records to another doctor at their/your request

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