MEDICAL/DENTAL HISTORY FORM

Date___________________________

Patient Name_______________________________________DOB_______________________________

Primary care physician____
Address____
Phone____
Date of last visit______________________ Up to date with immunizations Y / N
Is your child being treated by a physician at this time? Y / N Reason_____________________________
____
Is your child taking any medications (prescription or over the counter), vitamins, or dietary supplements? Y / N List and describe____
____
Allergies List, include type or severity of reaction____
____

Pharmacy Name____
Address____
Phone____

Has the child ever had any of the following medical problems?
Complications with birth, birth defects, syndrome or inherited conditions.......................................Y / N
Problems with physical growth and development...Y / N
Sinusitis, chronic adenoid/tonsil infections..Y / N
Sleep apnea/snoring, mouth breathing, or excessive gagging..Y / N
Congenital heart defect/disease, heart murmur, rheumatic fever or disease......................................Y / N
Irregular heart beat or high blood pressure...Y / N
Asthma, reactive airway disease, wheezing, or respiratory problems..Y / N
Liver, Kidney, or bladder problems..Y / N
Kidney or bladder problems...Y / N
Gastroesophageal/acid reflux (GERD) or other intestinal disorders..Y / N
Food allergies, lactose intolerance, nutritional deficiencies, dietary restrictions.................................Y / N
Arthritis, scoliosis, or other muscle/bone/joint problems...Y / N
Rash/hives, eczema or skin problems..Y / N
Impaired hearing, vision, or speech...Y / N
Recurrent or frequent headaches/migraines, fainting, or dizziness...Y / N
Hydrocephaly or placement of a shunt...Y / N
Developmental, learning, or intellectual disorder, including ADD/ADHD..Y / N
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures..Y / N
Autism or Autism spectrum disorder..Y / N
Behavioral, emotional, communication, or psychiatric problems..Y / N
History of Abuse (physical, emotional, or sexual) or neglect...Y / N

Diabetes, hyper or hypoglycemia……………………………………………………Y / N
Thyroid, pituitary, or hormonal problems……………………………………………Y / N
Anemia, sickle cell disease/trait, or bleeding disorder…………………………………Y / N
Transfusions or receiving blood products……………………………………………Y / N
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant……………………………………………………………Y / N
Tuberculosis or HIV/AIDS………………………………………………………………Y / N
Any operations or hospital stays………………………………………………………Y / N
Provide details here____
____

What is your primary concern about your child's dental health?____________________
____
How would you describe your child's oral health? Excellent Good Fair Poor
Is there a family history of cavities? Y / N If yes, circle all that apply: Mother Father Brother or Sister
Is there any history of dental trauma? Y / N If so, describe?____________________
____
How often does your child brush and does anyone help?____________________
How often does your child floss and does anyone help?____________________
What toothpaste and toothbrush does your child use?____________________
What is the source of your drinking water (city, well, or bottled water)____________________
Do you use a water filter? Y / N If yes, what type____________________
Does your child take fluoride supplements? Y / N
Does your child have any of the following habits?

- ☐ Thumb/Finger sucking
- ☐ Lip sucking/biting
- ☐ Nail biting
- ☐ Nursing or bottle

Is your child a "picky" eater? Y / N Please describe____________________
____
Does your child have a high carbohydrate diet?____________________
How frequently does your child have the following (please circle):

Candy or other sweets	Rarely	1-2 times/day	3 or more times/day
Chewing gum	Rarely	1-2 times/day	3 or more times/day
Soft drinks	Rarely	1-2 times/day	3 or more times/day
Between meal snacks	Rarely	1-2 times/day	3 or more times/day

Does your child participate in any contact sports? Y / N
If so, do they wear a mouthguard? Y / N
How do you think your child will respond to dental treatment?____________________
____
Previous/present dentist____
Date of last dental visit____________________ Reason____________________
Date of last dental x-rays____________________

The information given is correct to the best of my knowledge and I understand that this information will be held in the strictest of confidence. I understand that it is my responsibility to inform this office of any changes in my child's health status.

Patient/Guardian Signature____

Consent:

I herby authorize the dentist to take x-rays, study models, photographs, or any aids deemed appropriate by the dentist in charge of my child's care to make a thorough diagnosis of my child's dental needs. I also authorize the dentist to perform any and all forms of treatment, medication and therapy that may be necessary for my child's dental health.

Patient/Guardian Signature____