

Pediatric Medical History

Child's legal name: _____ Preferred name: _____ Date of birth: ____/____/____
 Birth sex: M F Current gender identity: _____ Pronouns: _____ Race/Ethnicity: _____ Height: _____ Weight: _____
 Name/age and relationship of others living in the household: _____
 Primary physician: _____ Address/phone: _____ Last visit: _____
 Medical specialists: _____ Address/phone: _____ Last visit: _____

- Is your child being treated by a physician at this time? Reason _____ YES NO
 Is your child taking any medication (prescription or 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 an anesthetic? Describe _____ YES NO
 Have you been told your child needs antibiotics or another medicine before dental treatment? Reason _____ YES NO
 Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____ YES NO
 Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____ YES NO
 Is your child up to date on immunizations against childhood diseases? YES NO
 Is your child immunized against human papilloma virus (HPV)? YES NO

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 at birth, prematurity, inherited conditions, syndromes, or birth defects (such as cleft lip/palate) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Problems with physical growth or development | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sinusitis, chronic adenoid/tonsil infections | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sleep apnea, snoring, or mouth breathing | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Irregular heart beat or high blood pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Asthma, reactive airway disease, wheezing, or breathing problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cystic fibrosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent colds or coughs, bronchitis, or pneumonia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent exposure to tobacco smoke | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Jaundice, hepatitis, or liver problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bladder or kidney problems or bedwetting | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Rash/hives, eczema, or skin problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Impaired vision, visual processing, hearing, or speech | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Developmental disorders, learning problems/delays, or intellectual disability | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Autism/autism spectrum disorder or sensory integration disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recurrent or frequent headaches/migraines, fainting, or dizziness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Attention deficit/hyperactivity disorder (ADD/ADHD) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Behavioral, emotional, communication, or psychiatric problems/treatment | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Abuse (physical, psychological, emotional, or sexual) or neglect | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes, hyperglycemia, or hypoglycemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Precocious puberty or hormonal problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Thyroid or pituitary problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Anemia, sickle cell disease/trait, or blood disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hemophilia, bruising easily, or excessive bleeding | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Transfusions or receiving blood products | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Corona virus disease 2019 (COVID-19), cytomegalovirus (CMV), human immunodeficiency virus (HIV)/AIDS, methicillin-resistant staphylococcus aureus (MRSA), mononucleosis, scarlet fever, sexually-transmitted disease (STD), or tuberculosis (TB) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

PROVIDE DETAILS HERE: _____

- Is there any other significant medical history pertaining to this child or the child's family that the dentist should be told? YES NO
 If YES, describe _____

What is your primary concern about your child's oral health? _____

How would you describe:

- your child's oral health? Excellent Good Fair Poor
- your oral health? Excellent Good Fair Poor
- the oral health of your other children? Excellent Good Fair Poor Not applicable

Is there a family history of cavities? YES NO If yes, indicate all that apply: Mother Father Brother Sister

Does your child have a history of any of the following? 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 jaws YES NO _____
- Clinching/grinding teeth YES NO _____
- Jaw joint problems (popping, etc.) YES NO _____
- Excessive gagging YES NO _____
- Sucking habit after one year of age YES NO If YES, how long? _____ Which? Finger Thumb Pacifier Other _____

How often are your child's teeth brushed? _____ times per _____ Does someone help your child brush? YES NO

How often are your child's teeth flossed? Never Occasionally Daily Does someone help your child floss? YES NO

What type of toothbrush does your child use? Hard Medium Soft Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? City/community supply Private well Bottled water

Do you use a water filter at home? YES NO If YES, type of filtering system: _____

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: _____

Does your child regularly eat 3 meals each day? YES NO

Is your child on a special or restricted diet? YES NO If YES, describe: _____

Is your child a 'picky eater'? YES NO If YES, describe: _____

Does your child have a diet high in sugars or starches? YES NO If YES, describe: _____

Do you have any concerns regarding your child's weight? YES NO If YES, describe: _____

How frequently does your child have the following?

- Snacks between meals Rarely 1-2 times/day 3 or more times/day Product _____
- Candy or other sweets Rarely 1-2 times/day 3 or more times/day Type _____
- Chewing gum Rarely 1-2 times/day 3 or more times/day Usual snack _____
- Soft drinks* Rarely 1-2 times/day 3 or more times/day Product _____

(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities? YES NO If YES, list: _____

Does your child wear a mouthguard during these activities? YES NO If YES, type: _____

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

If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? YES NO Date of most recent dental X-rays: _____

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/guardian _____

Relationship to child _____

Date _____

Signature of staff member reviewing history _____

Sleep & Breathing Questions

Please indicate if your child experiences or has experience any of the symptoms below by using the scale to measure the severity of these symptoms.

0 - No Occurrence 1 - Occurs Rarely 2 - Occurs 2 to 4 times per week 3 - Occurs 5 to 7 times per week

- _____ Snoring _____ Wakes up at night
- _____ Mouth breathing while sleeping _____ Wets the bed or pull ups (currently)
- _____ Mouth breathing during the day _____ History of bedwetting
- _____ Restless sleep _____ Feels sleepy waking up or during the day
- _____ Grinding teeth while sleeping _____