



Patient Medical History

Child's Full Name: _____ Nickname: _____ Date of birth: ____/____/____
 Gender: M F Race/Ethnicity: _____ Height: _____ Weight: _____ Date of last physical examination: _____
 Name/address/phone of primary physician: _____
 Name/address/phone of medical specialists: _____

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
 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

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 during birth, prematurity, birth defects, syndromes, or inherited conditions	<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, mouth breathing, or excessive gagging	<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, 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rash/hives, eczema or skin problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Impaired vision, 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, epilepsy, or convulsions/seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autism/autism spectrum 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, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Provide Details Here: _____

Is there any other significant medical history **pertaining to this child or his/her 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?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	
your oral health?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	
the oral health of your other children?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Not Applicable

Is there a family history of cavities? Yes No
If Yes, indicate all that apply: Mother Father Sister Brother

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Mouth sores or fever blisters	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bad breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bleeding gums	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cavities/decayed teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Toothache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Injury to teeth, mouth or jaws	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Clinching/grinding his/her teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Jaw joint problems (popping, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Excessive gagging	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Sucking habit after one year of age	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

If Yes, Which? Finger Thumb Pacifier Other For how long? _____

How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? Yes No

How often does your child floss his/her teeth? 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?	<input type="checkbox"/> City/community supply	<input type="checkbox"/> Private Well	<input type="checkbox"/> Bottled Water
Do you use a water filter at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, type of filtering system: _____
Please check all sources of fluoride your child receives:			
<input type="checkbox"/> Drinking water	<input type="checkbox"/> Toothpaste	<input type="checkbox"/> Over-the-counter rinse	<input type="checkbox"/> Prescription rinse/gel
<input type="checkbox"/> Fluoride treatment in the dental office	<input type="checkbox"/> Fluoride varnish by pediatrician/other practitioner	<input type="checkbox"/> Other: _____	
Does your child regularly eat 3 meals each day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is your child on a special or restricted diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, describe: _____
Is your child a 'picky eater'?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, describe: _____
Does your child have a diet high in sugars or starches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, describe: _____
Do you have any concerns regarding your child's weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, describe: _____
How frequently does your child have the following?			
Candy or other sweets	<input type="checkbox"/> Rarely	<input type="checkbox"/> 1-2 times/day	<input type="checkbox"/> 3 or more times/day Product _____
Chewing gum	<input type="checkbox"/> Rarely	<input type="checkbox"/> 1-2 times/day	<input type="checkbox"/> 3 or more times/day Type _____
Snacks between meals	<input type="checkbox"/> Rarely	<input type="checkbox"/> 1-2 times/day	<input type="checkbox"/> 3 or more times/day Usual snack _____
Soft drinks*	<input type="checkbox"/> Rarely	<input type="checkbox"/> 1-2 times/day	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, list: _____
Does your child wear a mouthguard during these activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, type: _____
Has your child been examined or treated by another dentist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If Yes: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____			
Were x-rays taken of the teeth or jaws?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of most recent dental x-rays: _____
Has your child ever had orthodontic treatment (braces, spacers, or other appliances)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when? _____
Has your child ever had a difficult dental appointment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, describe: _____
How do you expect your child will respond to dental treatment	<input type="checkbox"/> Very well	<input type="checkbox"/> Fairly well	<input type="checkbox"/> Somewhat poorly
	<input type="checkbox"/> Very poorly		
Is there anything else we should know before treating your child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If Yes, describe: _____			

_____	_____	_____	_____
Signature of parent/guardian	Relationship to child	Date	Signature of staff member reviewing history