



# Pediatric Medical & Dental History



Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_ Gender  M  F

Name of Physician & Date of last physical examination \_\_\_\_\_

**Antibiotic PRE-MED: Does your child require antibiotics prior to dental treatment?**  Yes  No

**Is this your child's first visit to a dentist?**  Yes  No **Date of your child's last dental exam** \_\_\_\_\_

**Has your child had dental radiographs in the last year?**  Yes  No

## Has your child have or ever had?

	Yes	No		Yes	No
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	26. tonsils and/or adenoids removed	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to:	<input type="checkbox"/>	<input type="checkbox"/>	Yes, at what age _____		
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			27. Does your child have any problems with:		
<input type="checkbox"/> penicillin <input type="checkbox"/> latex			<input type="checkbox"/> concentrating <input type="checkbox"/> learning		
<input type="checkbox"/> other antibiotics <input type="checkbox"/> food			<input type="checkbox"/> cooperating <input type="checkbox"/> sensitive to sounds, bright		
<input type="checkbox"/> local anesthetic			<input type="checkbox"/> understanding lights, etc		
<input type="checkbox"/> metals (nickel, gold, silver)			28. Do you feel your child will be a cooperative patient?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> food			29. viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			30. speech difficulties	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems	<input type="checkbox"/>	<input type="checkbox"/>	31. problems with dental visits in the past	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	32. any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect	<input type="checkbox"/>	<input type="checkbox"/>	33. problems with the eruption or shedding of teeth	<input type="checkbox"/>	<input type="checkbox"/>
6. high or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	34. orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>
7. anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	35. if yes, name of orthodontist and date of treatment	<input type="checkbox"/>	<input type="checkbox"/>
8. prolonged bleeding due to a slight cut (INR >3.5)	<input type="checkbox"/>	<input type="checkbox"/>	36. what type of water does your child drink?		
9. tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> city water <input type="checkbox"/> bottled water		
10. asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> well water <input type="checkbox"/> filtered water		
11. breathing or sleep problems (i.e. snoring, sinus)	<input type="checkbox"/>	<input type="checkbox"/>	37. does your child take fluoride supplements	<input type="checkbox"/>	<input type="checkbox"/>
12. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	38. is fluoride toothpaste used	<input type="checkbox"/>	<input type="checkbox"/>
13. liver disease	<input type="checkbox"/>	<input type="checkbox"/>	39. how many times a day and when are the child's teeth brushed _____		
14. thyroid	<input type="checkbox"/>	<input type="checkbox"/>	40. do you assist your child with tooth brushing	<input type="checkbox"/>	<input type="checkbox"/>
15. diabetes	<input type="checkbox"/>	<input type="checkbox"/>	41. does your child suck their thumb, fingers or pacifier	<input type="checkbox"/>	<input type="checkbox"/>
16. digestive disorders (i.e. heartburn or gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>	42. does the child participate in active recreational activities	<input type="checkbox"/>	<input type="checkbox"/>
17. injuries to the head, neck, teeth or face	<input type="checkbox"/>	<input type="checkbox"/>	43. What are specific concerns for your child's teeth?		
18. epilepsy, convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____		
19. hepatitis or HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____		
20. tumor or abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>			
21. radiation or chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>			
22. psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>			
23. often unhappy, depressed or emotionally impaired	<input type="checkbox"/>	<input type="checkbox"/>			
24. substance abuse	<input type="checkbox"/>	<input type="checkbox"/>			
25. frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any serious illness, medical treatment, impending surgery, genetic / developmental anomalies, or other medical concerns that may possibly affect your dental treatment.

Drug / Dose

Drug / Dose

**Please advise us in the future of any change in your medical history or any medications the patient may be taking**

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_