

PEDIATRIC DEPARTMENT

CHILD'S NAME M F

NAME REFERED AGE DATE OF BIRTH

WEIGHT HEIGHT

DENTAL HISTORY

HOW OFTEN DOES YOUR CHILD BRUSH?

IS TOOTHBRUSHING SUPERVISED? Y N

BY WHOM?

IS DENTAL FLOSS USED? Y N

DOES YOUR CHILD RECEIVE:

- Fluoride in vitamins
- Fluoride in tablets/drops
- Fluoridated water
- Bottled water
- Well water

CHILD'S FIRST DENTAL VISIT? Y N

PREVIOUS DENTIST CITY

DATE OF LAST VISIT

DATE OF LAST DENTAL X-RAYS

ANY INJURIES TO CHILD'S TEETH OR JAWS? Y N WHEN?

ANY RECENT DENTAL PAIN?

HISTORY OF:

BREAST FEEDING

BOTTLE HABITS

THUMB/FINGER SUCKING

PACIFIER

DENTAL GRINDING/CLENCHING

PAIN IN JAW JOINTS

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL/DENTAL CARE?

Y N (IF YES, PLEASE EXPLAIN)

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST?

MEDICAL HISTORY

DOES YOUR CHILD HAVE A HISTORY OF HEALTH PROBLEMS? Y N IF YES, PLEASE EXPLAIN

PHYSICIAN/PEDIATRICIAN'S NAME

ADDRESS

PHONE NO.

DATE OF LAST PHYSICAL EXAM

IS YOUR CHILD PRESENTLY UNDER THE CARE OF A SPECIALIST FOR ANY MEDICAL REASON? Y N

IF YES, FOR WHAT?

SPECIALIST'S NAME

PHONE NO.

ARE ANTIBIOTICS NEEDED FOR DENTAL WORK DUE TO HEART MURMUR, HEART DEFECT, PROSTHESIS, SHUNT OR OTHER REASON? Y N

IS YOUR CHILD PRESENTLY TAKING ANY MEDICATIONS? Y N WHAT?

IS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? Y N FOR WHAT?

IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? Y N PLEASE LIST

IS YOUR CHILD ALLERGIC TO ANY DYES OR FOODS? Y N PLEASE LIST

IS YOUR CHILD ALLERGIC TO ANY ENVIRONMENTAL POLLUTANTS? Y N

IS YOUR CHILD ALLERGIC TO METALS (SNAPS)? Y N

IS YOUR CHILD ALLERGIC TO LATEX? Y N

HAS YOUR CHILD OR ANY MEMBER OF YOUR FAMILY HAD A PROBLEM WITH A GENERAL ANESTHETIC? Y N

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

- | | |
|--|--|
| Y N ADD/ADHD | Y N Eye Problem |
| Y N AIDS/HIV | Y N Excessive Bleeding Problem |
| Y N Anemia | Y N Excessive Gagging |
| Y N Asthma (IF YES, WHAT TRIGGERS IT?) | Y N Fainting or Dizziness |
| | Y N Growth/Developmental Problems |
| Y N Autism Spectrum Disorder | Y N Heart Surgery |
| Y N Autism | Y N Heart Murmur/Defect |
| Y N Bladder Conditions | Y N Headaches |
| Y N Blood Disease | Y N Hearing/Speech Impediments |
| Y N Blood Transfusions | Y N Hemophilia |
| Y N Birth Defects | Y N Hepatitis/Liver Disease |
| Y N Bone/Joint Problems | Y N High Blood Pressure |
| Y N Brain Injury | Y N Kidney Disease |
| Y N Bruising Easily | Y N Mental Disability |
| Y N Cancer | Y N Mouth Sores |
| | Y N Nutritional Deficiency |
| Y N Cerebral Palsy | Y N Premature Birth |
| Y N Child Abuse | Y N Psychiatric Care |
| Y N Chronic Adenoid/Tonsil Infection | Y N Rheumatic Fever |
| Y N Chronic Ear Infections | Y N Scoliosis |
| Y N Cleft Lip/Palate | Y N Sickle Cell Anemia |
| Y N Convulsion/Seizures | Y N Syndrome |
| Y N Developmentally Delayed | Y N Tuberculosis |
| Y N Diabetes | Y N Other |
| Y N Emotional Disturbance | |
| Y N Epilepsy | Y N Do you wish to talk to the doctor privately about a special concern? |