Compass Health Network

# *Pediatric Patient Medical History*

Patient Name:_____ Date of Birth: _____

Primary Care Physician: _____ Facility Name: _____ Date of last exam: _____

Is your child under medical treatment by a primary care physician or a specialty doctor? If yes, please describe:

_____

Has your child been hospitalized, had any surgeries, or have they been treated in an emergency department? If yes, please explain:

_____

Have you ever been told your child needs to take an antibiotic or other medicine before dental treatment? If yes, please explain:

_____

Please list all prescription and non-prescription medications your child is taking, including any over-the-counter medicines, vitamins, or herbal supplements:

_____

**Is your child allergic to or have they had any reactions to the following:**

| | Yes | No | If yes, what is the reaction? |
|---|---|---|---|
| Local Anesthetics (e.g. Lidocaine or Septocaine) | ☐ | ☐ | |
| Penicillin/Amoxicillin | ☐ | ☐ | |
| Other Antibiotics | ☐ | ☐ | |
| Other Medications | ☐ | ☐ | |
| Sedatives | ☐ | ☐ | |
| Aspirin | ☐ | ☐ | |
| Any metals (e.g. nickel, mercury, silver, etc.) | ☐ | ☐ | |
| Latex Rubber | ☐ | ☐ | |
| Red Dye | ☐ | ☐ | |
| Other Allergies: | ☐ | ☐ | |
| Food Allergies: | ☐ | ☐ | |

**Does your child have, or have they had, any of the following?**

| | Yes | No | If yes, please explain: |
|---|---|---|---|
| Complications before or at birth, prematurity, inherited conditions, syndromes, or birth defects (e.g. Cleft lip/palate) | ☐ | ☐ | |
| Sinusitis, chronic adenoid/tonsil infections | ☐ | ☐ | |
| Sleep apnea, snoring, mouth breathing | ☐ | ☐ | |
| Congenital heart defect/disease, heart murmur, rheumatic fever, rheumatic heart disease | ☐ | ☐ | |
| Irregular heart beat or high blood pressure | ☐ | ☐ | |
| Asthma, reactive airway disease, wheezing, or breathing problems | ☐ | ☐ | |
| Cystic fibrosis | ☐ | ☐ | |
| Jaundice, hepatitis, or liver problems | ☐ | ☐ | |
| Gastroesophageal/acid reflux (GERD), stomach ulcer, or intestinal problems | ☐ | ☐ | |
| Bladder or kidney problems | ☐ | ☐ | |
| Rash/hives, eczema, or skin problems | ☐ | ☐ | |
| Impaired vision, visual processing, hearing or speech problems | ☐ | ☐ | |
| Developmental disorders, learning problems/delays, or intellectual disability | ☐ | ☐ | |

Doctor's Initials ☐ Date ☐

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| | Yes | No | If yes, please explain: |
|---|---|---|---|
| Cerebral palsy, brain injury, concussion, epilepsy, seizures | ☐ | ☐ | |
| Autism/Autism Spectrum Disorders or sensory integration disorders | ☐ | ☐ | |
| Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) | ☐ | ☐ | |
| Attention deficit/hyperactivity disorder (ADD/ADHD) | ☐ | ☐ | |
| Behavioral, emotional, communication, or psychiatric problems/treatment | ☐ | ☐ | |
| Diabetes, hyperglycemia, or hypoglycemia | ☐ | ☐ | |
| Precocious puberty or hormonal problems | ☐ | ☐ | |
| Thyroid or pituitary problems | ☐ | ☐ | |
| Anemia, sickle cell disease/trait, or blood disorder | ☐ | ☐ | |
| Hemophilia, bruising easily, excessive bleeding | ☐ | ☐ | |
| Transfusions or receiving blood products | ☐ | ☐ | |
| Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant | ☐ | ☐ | |
| Human immunodeficiency virus (HIV) | ☐ | ☐ | |
| Tobacco, vape, marijuana, alcohol, other recreational drugs? | ☐ | ☐ | |

**Please list any other significant medical history pertaining to this child or the child's family that the dentist should know about:**

_____

**Child's Dental History:**

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

How often are your child's teeth brushed? ____ times per _____ How often are your child's teeth flossed? ☐ Never ☐ Occasionally ☐ Daily

Does someone help brush your child's teeth? ☐ Yes ☐ No What toothpaste does your child use? _____

Has your child been examined or treated by another dentist? ☐ Yes ☐ No; *If Yes*, Age at First Visit: _____ Date of Last Visit: _____

Has your child ever had a difficult dental appointment? ☐ Yes ☐ No; *If Yes, please describe:* _____

How do you expect your child will respond to dental treatment? ☐ Very well ☐ Fairly well ☐ Somewhat poorly ☐ Very poorly

**Dietary Questionnaire:**

Does your child regularly eat 3 meals each day? ☐ Yes ☐ No

Is your child a "picky eater" ☐ Yes ☐ No If yes, please explain: _____

Is your child on a restricted/special diet? ☐ Yes ☐ No If yes, please explain: _____

How frequently does your child have the following:

Snacks between meals ☐ Rarely ☐ 1-2/day ☐ 3+/day

Candy or other sweets ☐ Rarely ☐ 1-2/day ☐ 3 or more times/day

Chewing gum ☐ Rarely ☐ 1-2/day ☐ 3+/day

Soft drinks or other sweetened beverages including juice, sports drinks, energy drinks ☐ Rarely ☐ 1-2/day ☐ 3+/day

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize the dental provider to reach out to a physician. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date