Patient Name: Date of Birth:

Does your have a primary care physician? No ☐ Yes ☐ Primary Care Physician:

Location of Physician: Date of last exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your preferred pharmacy? (name & address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Medical History**

Is your child under medical treatment by a specialty doctor? No ☐ Yes ☐

Has your child ever been hospitalized, had any surgeries, or been treated in an emergency department? No ☐ Yes ☐

Have you been told your child needs to take an antibiotic or other medicine before dental treatment? No ☐ Yes ☐

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is your child allergic to or have they had any reactions to the following? Select all that apply

|  |  |  |  |
| --- | --- | --- | --- |
| Local Anesthesia (e.g. Lidocaine or Septocaine) | ☐ | Aspirin | ☐ |
| Penicillin/Amoxicillin | ☐ | Latex Rubber | ☐ |
| Food Allergies | ☐ | Red Dye | ☐ |
| Other Antibiotics (Including Sulfas) | ☐ | Any Metals (e.g. Nickel, Mercury, etc.) | ☐ |
| Other Medications | ☐ | Other Allergies | ☐ |
| Sedatives | ☐ | None | ☐ |

Does your child have, or have they had, any of the following medical conditions? Select all that apply

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anemia, sickle cell disease/trait, or blood disorder | ☐ | Developmental disorders, learning problems/delays, or intellectual disability | ☐ | Mouth breathing | ☐ |
| Asthma, reactive airway disease, wheezing, or breathing problems | ☐ | Diabetes, hyperglycemia, or hypoglycemia | ☐ | Precocious puberty or hormonal problems | ☐ |
| Attention deficit/hyperactivity disorder (ADD/ADHD) | ☐ | Gastroesophagea/acid reflux (GERD), stomach ulcer, or intestinal problems | ☐ | Rash/hives, eczema, or skin problems | ☐ |
| Autism/autism spectrum disorders, or sensory integration disorders | ☐ | Heart murmur | ☐ | Sinusitis, chronic adenoid/tonsil infections | ☐ |
| Behavioral, emotional, communication, or psychiatric problems/treatment | ☐ | Hemophilia, bruising easily, excessive bleeding | ☐ | Sleep apnea | ☐ |
| Bladder or kidney problems | ☐ | Human immunodeficiency virus (HIV) | ☐ | Snoring | ☐ |
| Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant | ☐ | Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) | ☐ | Thyroid or pituitary problems | ☐ |
| Cerebral palsy, brain injury, concussion, epilepsy, seizures | ☐ | Impaired vision, visual processing, hearing or speech problems | ☐ | Tobacco, vape, marijuana, alcohol, other recreational drugs | ☐ |
| Congenital heart defect/disease, rheumatic fever, rheumatic disease | ☐ | Irregular heartbeat or high blood pressure | ☐ | Transfusions or receiving blood products | ☐ |
| Cystic Fibrosis | ☐ | Jaundice, hepatitis, or liver problems | ☐ | None of the above | ☐ |

Please list any other significant medical history pertaining to this child or the child’s family that the provider should know about.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Child’s Dental History**

What is your primary concern about your child’s oral health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a history of any of the following?

* Inherited dental characteristics No☐ Yes ☐
* Mouth sores or fever blisters No☐ Yes ☐
* Bad Breath No☐ Yes ☐
* Bleeding Gums No☐ Yes ☐
* Cavities/decayed teeth No☐ Yes ☐
* Toothache No☐ Yes ☐
* Injury to teeth, mouth, jaws No☐ Yes ☐
* Clenching/grinding teeth No☐ Yes ☐
* Jaw joint problems (e.g. popping, etc. ) No☐ Yes ☐
* Excessive gagging No☐ Yes ☐
* Sucking habit after one year of age? No☐ Yes ☐ Which: Finger ☐ Thumb ☐ Pacifier ☐ Other ☐

How often are your child’s teeth brushed?

☐ Never

☐ Once daily

☐ Twice daily

☐ Three times daily

☐ Once weekly

☐ Every few days

How often are your child’s teeth flossed? Never☐ Daily ☐ Occasionally ☐

What type of toothpaste does your child use?

☐ Fluoride toothpaste

☐ Non-fluoride toothpaste

☐ Training toothpaste

☐ Not sure

Has your child been examined or treated by another dentist? No☐ Yes ☐

When was your child’s first visit to the dentist? (month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental visit. (month/year) \_\_\_\_\_\_\_\_\_\_\_

Has your child ever had a difficult dental appointment? No☐ Yes ☐

How do you expect your child will respond to dental treatment?

☐ Very well

☐ Fairly well

☐ Somewhat poorly

☐ Very poorly

Does your child regularly eat 3 meals each day? No☐ Yes ☐ Is your child a “picky”eater? No☐ Yes ☐

Is your child on a restricted/special diet? No☐ Yes ☐

|  |  |  |  |
| --- | --- | --- | --- |
| **How frequently does your child have the following?** | Rarely | 1-2 Daily | 3 or more |
| Snacks between meals | ☐ | ☐ | ☐ |
| Candy or other sweets | ☐ | ☐ | ☐ |
| Chewing Gum | ☐ | ☐ | ☐ |
| Soft drinks or other sweetened beverages (including milk, juice, sports drinks, and energy drinks) | ☐ | ☐ | ☐ |