MEDICAL HISTORY

Date: ____ /____ /____

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pediatric dentistry

Patient's Name:______________________________DOB:_______/_________/_________

Name of person completing health questionnaire:______________________________ Relation:____________________

Reason for today's visit: Establish care (new patient) | Emergency | Referred by: ______________ | Other:__________________

Allergies

Y | N If yes, please select: ☐ Antibiotics (ex. Penicillin/Amoxicillin, etc): ______________________________

☐ Aspirin ☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil) ☐ Latex ☐ Metals ☐ Dental Anesthetics

☐ Other: ____________________ Please explain type/symptoms of reaction:______________________________

Airway

Y | N Does your child *currently* have any of the following sleep problems? ☐ Snoring ☐ Restlessness ☐ Sleep Apnea ☐ Other

Please elaborate as needed: ____

Immunizations

Y | N Immunizations/vaccinations up to date If no, please explain: ______________________________

Medical History **Does your child have (or has he/she ever had) any of the following conditions?** ☐ NO to all, child is HEALTHY

☐ Anaphylactic Reaction- cause: __________________

☐ ADHD

☐ AIDS/HIV

☐ Anemia

☐ Asthma- mild / moderate / severe

Date inhaler was last used: ____________________

Caused by: ______________________________

☐ Autism- mild / moderate / severe

☐ Bleeding Disorder (ex. Hemophilia, vWD)

Type: ______________________________

☐ Blood Transfusion- date(s): ____________________

☐ Blood Pressure ☐ High ☐ Low

☐ Cancer- type: ____________________________

Date of Diagnosis: ____________________________

☐ In therapy ☐ In remission

Y | N **Port present requiring antibiotic premedication?**

☐ Cerebral Palsy- mild / moderate / severe

☐ Chemotherapy/Radiation Treatment: ☐ Past ☐ Present

Date(s) of treatment:______________________

☐ Cleft Lip / Cleft Palate

☐ Developmental Delay- mild / moderate / severe

☐ Diabetes- Type I / Type II

Last HbA1C: __________ Date taken: ____________

☐ Disability/Syndrome

Describe/List: ______________________________

☐ Heart Murmur, innocent

☐ Heart Defect- Type: __________________________

☐ Repair not required Date of repair: ___________

Y | N Does defect require antibiotic premedication?

☐ Hepatitis- Type A / B / C

☐ Intellectual Delay- mild / moderate / severe

☐ Mouth sores- canker sores / cold sores / ulcers

Frequency: occasionally / monthly / weekly

☐ Obsessive Compulsive Disorder (OCD)

☐ Oppositional Defiant Disorder (ODD)

☐ Pregnant (females)

☐ Premature Birth- Gestational Age at Birth: _____ weeks

☐ Seizures (ex. Epilepsy)

Last seizure: ____________ Y | N carries rescue med

☐ Sickle Cell Anemia

☐ Special Diet- Please explain: __________________

☐ G-tube fed (% nutrient intake through G-tube: _____)

☐ Speech Delay- mild / moderate / severe

☐ Thalassemia- alpha / beta

☐ Tobacco Use

☐ **Any other condition not listed here (please specify):** ____

Please elaborate as needed:____

____

PLEASE TURN OVER→

MEDICAL HISTORY

Date: ____ /____ /____

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Other

- ☐ Cardiac Problems ____________________
- ☐ Gastrointestinal Problems ____________________
- ☐ Hearing/Speech Problems ____________________
- ☐ Kidney Problems ____________________
- ☐ Liver Problems ____________________
- ☐ Muscular Problems ____________________
- ☐ Respiratory Problems ____________________
- ☐ Thyroid Problems ____________________
- ☐ Vision Problems ____________________

Y | N Has your child ever been **hospitalized?**

Date and Reason: ____________________

Y | N Has your child ever had **surgery?**

Date and Reason: ____________________

Any complications with anesthetic or recovery? ____________________

Please list any condition(s) not listed above: ____________________

____

Medical Provider/Primary Care Physician Information:

Primary Care Physician: ____________________ Phone #: ____________________

Practice Name: ____________________ City: ____________________ State: ________ Zip: ____________________

Medical Specialists (Please list all the medical specialists under which your child receives care.)

	Physician/Specialist's Name	Specialty (ex. Cardiology)	Hospital Name	Hospital Location (City, State)
1				
2				
3				
4				

Medications

	Medication Name	Dosage	What is it taken for?
1			
2			
3			
4			
5			
6			