MEDICAL-DENTAL HISTORY

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_ Place of Birth

 Last, first, nickname

Date of last medical examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Physician/pediatrician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone

Physician’s address

## PLEASE EXPLAIN ANY “YES” ANSWERS IN THE MARGINS

**MEDICAL HISTORY**

**GROWTH AND DEVELOPMENT:**

Any learning, behavioral, excessive nervousness, or communication problems? (If yes, indicate below) No ( ) Yes ( )

 **Diagnosis** (circle): ADD/ADHD Autism Spectrum Bipolar Dev. Delay OCD ODD PTSD Speech Delay Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has child had psychological counseling or is counseling being considered for the near future? No ( ) Yes ( )

Were there any complications during pregnancy or was child premature at birth? No ( ) Yes ( )

Any problems with physical growth? No ( ) Yes ( )

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**CENTRAL NERVOUS SYSTEM:**

Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness? No ( ) Yes ( )

Any history of injury to the head No ( ) Yes ( )

Any sensory disorders (seeing, hearing)? No ( ) Yes ( )

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**CARDIOVASCULAR SYSTEM:**

Any history of congenital heart disease, heart murmur, or heart damage from rheumatic fever? No ( ) Yes ( )

Has any heart surgery been done or recommended? No ( ) Yes ( )

Any history of chest pains or high blood pressure ? No ( ) Yes ( )

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**HEMATOPOIETIC AND LYMPHATIC SYSTEMS:**

Has your child ever had a blood transfusion or blood product transfusion? No ( ) Yes ( )

Any history of anemia or sickle cell disease? No ( ) Yes ( )

Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts? No ( ) Yes ( )

Is your child more susceptible to infections than other children? No ( ) Yes ( )

Is there any history of tender or swollen lymph nodes or glands? No ( ) Yes ( )

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**RESPIRATORY SYSTEM:**

Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty breathing? No ( ) Yes ( )

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**GASTROINTESTINAL SYSTEM:**

Any history of stomach, intestinal or liver problems No ( ) Yes ( )

Any history of hepatitis or jaundice? No ( ) Yes ( )

Any history of eating disorders, such as anorexia nervosa or bulimia? No ( ) Yes ( )

Any history of unintentional weight loss? No ( ) Yes ( )

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**GENITOURINARY SYSTEM:**

Any history of urinary tract infections, bladder or kidney problems? No ( ) Yes ( )

Is the patient pregnant or possibly pregnant? No ( ) Yes ( )

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**ENDOCRINE SYSTEM:**

Any history of diabetes? No ( ) Yes ( )

Any history of thyroid disorders or other glandular disorders? No ( ) Yes ( )

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**SKIN:**

Any history of skin problems?(circle): Eczema Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No ( ) Yes ( )

Any history of cold sores (herpes) or canker sores (aphthae)? No ( ) Yes ( )

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**EXTREMITIES:**

Any limitations of use of arms or legs? No ( ) Yes ( )

Any arthritis, joint bleeding, joint replacements, or other joint problems? No ( ) Yes ( )

Any problems with muscle weakness or muscular dystrophy? No ( ) Yes ( )

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**ALLERGIES:**

Is your child allergic to any medications? No ( ) Yes ( )

 If Yes, List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any hay fever, hives, or skin rashes caused by allergies? No ( ) Yes ( )

Any other allergies? No ( ) Yes ( )

 If Yes, List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICATIONS OR TREATMENTS:**

Is your child currently taking any medication (prescription or non-prescription)? No ( ) Yes ( )

If yes, Medication (s) Diagnosis Dosage Times Per Day

Has your child ever received therapy (x-ray treatments) or is it planned No ( ) Yes ( )

Has your child ever received chemotherapy or is it planned No ( ) Yes ( )

**HOSPITALIZATIONS:** Has your child ever been hospitalized? No ( ) Yes ( )

Hospital

Date

Reason

**IMMUNIZATIONS:**

Is your child up to date on vaccines and immunizations? No ( ) Yes ( )

**Please check any of the following that your child has now, has recently been exposed to, or has had in the past.**

#  NOW EXPOSED PAST

Chicken pox (varicella)

Earache (otitis)

Eye infection (conjunctivitis)

German measles or 3-day measles (rubella)

Glandular fever or mono (infectious mono)

HIV/AIDS

Lead poisoning

Measles (rubella)
Mumps (parotitis)

Scarlet Fever (scarlatina)

Sore throat (tonsillitis or pharyngitis)

Substance abuse, alcoholism, drug addiction

Tuberculosis

Upper respiratory infection (URI) or common cold

 Pharyngitis, rhinitis, sinusitis, or tonsillitis)

 Venereal disease (genital herpes, gonorrhea,

 Syphilis, or other)

**DENTAL DISEASE PREVENTION & ORAL HABITS**

How often does your child brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_times per\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child use dental floss? No ( ) Yes ( )

Does someone assist your child with brushing and cleaning teeth? No ( ) Yes ( )

Does someone inspect for thoroughness after the procedure? No ( ) Yes ( )

Does your child use fluoride toothpaste? No ( ) Yes ( )

Drinking water source: City water supply\_\_\_\_\_\_\_\_\_\_ Name of city\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Private well or other than city\_\_\_\_\_\_\_\_\_\_\_\_\_ Has a fluoride analysis been done? \_\_\_\_\_\_\_\_\_\_

 Date of analysis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fluoride content\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child fail to eat a well-balanced diet? No ( ) Yes ( )

If yes, what foods or food groups are not adequate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does (or has) your child have (or had) any of these habits beyond one year of age? (If yes, check) No ( ) Yes ( )

 Thumb-sucking \_\_\_\_\_ Finger-sucking \_\_\_\_\_ Pacifier \_\_\_\_\_ Lip biting \_\_\_\_\_

 Mouth breathing \_\_\_\_\_ Nail biting \_\_\_\_\_ Teeth grinding \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does (or has) your child have (or had) difficulty opening his or her mouth, or does the child’s jaw

sometimes lock or stick in a certain position? No ( ) Yes ( )

Does (or has) your child have (or had) popping or clicking noises or pain during chewing or yawning? No ( ) Yes ( )

Does (or has) your child have (or had) frequent headaches or pain in or about the ears, eyes, or cheeks? No ( ) Yes ( )

**DENTAL HISTORY (*New Patients ONLY*)**

Has your child ever had a fluoride treatment? No ( ) Yes ( )

Has your child ever taken a fluoride supplement or vitamins with fluoride? No ( ) Yes ( )

Does your child have a toothache or other immediate dental problems? No ( ) Yes ( )

Has your child ever had a toothache? No ( ) Yes ( )

Has your child had any injury to the mouth, teeth, or jaws (fall, blow, etc.)? No ( ) Yes ( )

Is this your child’s first dental visit? No ( ) Yes ( )

If no: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had an unfavorable dental experience? No ( ) Yes ( )

Is (was) your child nourished by nursing beyond age one? No ( ) Yes ( )

If yes, check: Breast\_\_\_\_\_\_\_\_ Nursing Bottle\_\_\_\_\_\_\_\_\_ Both\_\_\_\_\_\_\_\_, and to what age? \_\_\_\_\_\_\_\_\_\_

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature (Parent or guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**