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 ( )

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 ( )

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 ( )

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 ( )

RESPIRATORY SYSTEM:

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

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 ( )

GENITOURINARY SYSTEM:

Any history of urinary tract infections, bladder or kidney problems?	No ( )	Yes ( )
Is the patient pregnant or possibly pregnant?	No ( )	Yes ( )

ENDOCRINE SYSTEM:

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

SKIN:

Any history of skin problems? (circle): Eczema Other:_____	No ( )	Yes ( )
Any history of cold sores (herpes) or canker sores (aphthae)?	No ( )	Yes ( )

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 ( )

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: _____		

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) _____