Patients Name ______________________

Date of Birth ______________________

PEDIATRIC DENTISTRY MEDICAL HISTORY FORM

DIRECTIONS: Please circle appropriate answers and fill in the blanks.
If you don't know an answer circle "(?)".
Please complete the front and the back.

MEDICAL HISTORY

Does the patient have any history of the following?

Heart problems or murmur	YES	NO	(?)
Bleeding or clotting problem	YES	NO	(?)
Sickle cell anemia or trait	YES	NO	(?)
Cleft lip or palate	YES	NO	(?)
Birth defects or genetic disorders	YES	NO	(?)
Epilepsy or seizures	YES	NO	(?)
Developmental disabilities	YES	NO	(?)
Growth problems	YES	NO	(?)
Cerebral Palsy	YES	NO	(?)
Autism	YES	NO	(?)
Ear or hearing problems	YES	NO	(?)
Speech Difficulties	YES	NO	(?)
Attention Deficit Disorder/Hyperactivity Disorder and/or Obsessive Compulsive Disorder	YES	NO	(?)
Vision Problems	YES	NO	(?)
Asthma or wheezing	YES	NO	(?)
Allergies (hay fever, latex sensitivity, etc)	YES	NO	(?)
Hepatitis or liver disease	YES	NO	(?)
Diabetes	YES	NO	(?)
Cancer	YES	NO	(?)
Tuberculosis	YES	NO	(?)
Kidney problems	YES	NO	(?)
Bone or joint problems	YES	NO	(?)
Smoking or use of snuff or smokeless tobacco	YES	NO	(?)
HIV or AIDS	YES	NO	(?)
Other medical problems (specify)	YES	NO	(?)

Name of patient's physician ______________________ Date of last visit ____________

Address ______________________ Phone Number ____________

Is the patient currently under the care of a physician? .... YES NO (?)

If yes, for what condition? ______________________

Is the patient currently taking any medications? .... YES NO (?)

If yes, list ______________________

for what condition ______________________

Has the patient had any allergic or unfavorable reactions to any medications? .... YES NO (?)

To what ______________________ Reaction ______________________

Has the patient had any surgeries .... YES NO (?)

Nature ______________________ Date ______________________

CONTINUE ON OTHER SIDE

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Patients Name________________________________

Date of Birth________________________________

Are the patients' immunizations up-to-date?..YES NO (?)

Is there any additional medical
information about the patient not reported above?............................YES NO (?)
If yes, describe________________________________

DENTAL HISTORY

Why is the patient seeking dental care________________________________

Is this the patient's first visit to the dentist...YES NO (?)
If no, give date of last visit________________________________

Has the patient had any of the following dental problems?

Injuries to the mouth or teeth...YES NO (?)
Toothaches...YES NO (?)
Abscesses (gum boils)..YES NO (?)
Other (specify)..YES NO (?)

Does the patient have any of the following habits?

Pacifier use... YES NO (?)
Finger or thumb sucking...YES NO (?)
Tooth grinding or clenching..YES NO (?)
Mouth breathing... YES NO (?)
Other (specify)________________________________

Does the patient receive fluoride tablets, drops or vitamins with fluoride?. YES NO (?)

At what age was bottle or breast feeding stopped? ________________________________

Who is responsible for brushing the patient's teeth?________________________________

SOCIAL AND BEHAVIORAL HISTORY

Do you think the patient will cooperate for dental treatment....................YES NO (?)

Has the patient had a bad or fearful dental or medical experience?..........YES NO (?)

Does the patient have any history of emotional or behavioral problems?...YES NO (?)
If yes, describe________________________________

Is there any additional information we should know?.............................YES NO (?)
If yes, comment________________________________

To the best of my knowledge the above information is correct.

________________________ ________________________ ________________________

Signature of person completing form Date Relationship to patient

Dentist's remarks and summary:________________________________

____

____

____

Updated________________________ **Reviewed by**________________________

Updated________________________ **Reviewed by**________________________

Updated________________________ **Reviewed by**________________________

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