For office use only: OR/IV/SED:_____ hours

Height: _____ inches Weight: _____lbs

Medical and Dental Health History

Dental History

Child's Name: ____

Person accompanying child today: ______________________________ Relationship: _______________________

Please rate the following:

How do you rate your child's current dental health 1 2 3 4 5 - most healthy
How do you rate the importance or priority of dental health 1 2 3 4 5 - high priority
Where would you like to see your child's dental health 1 2 3 4 5 - most healthy

Is your child currently experiencing discomfort? ☐Yes ☐No

Is this your child's first time seeing a dentist? ☐Yes ☐No
If No, Please describe child's previous experience: ____

Previous Dentist: ________________________________Date of Last visit: ____/____/____ Films taken? ☐ Y ☐ N

Yes No

☐ ☐ Does your child brush his/her teeth? How often?___________________With help?____________________

☐ ☐ Does your child floss? How often? __________________________With help? ____________________

☐ ☐ Did/Does your child go to bed with a bottle? Contents: ____

☐ ☐ Is/Was your child nursed to sleep?_________________________

☐ ☐ Is/Was your child breast fed? Until what age?___________

☐ ☐ Does your child have any habits?_____________________________

☐ ☐ Does your child clench or grind his/her teeth? ___________

(Circle all that apply): nail biting thumb sucking mouth breathing pacifier cheek biting tongue thrusting

☐ ☐ Is your child taking fluoride supplements?

☐ ☐ Is your child's water fluoridated? Source: City Well Bottled Other ____________________________

☐ ☐ Has your child ever seen an orthodontist? If yes, who? ____

☐ ☐ Has your child ever experienced trauma to the lips, chin, teeth or gums? If yes when?: ____________________
Please explain:____

☐ ☐ Has your child ever had any adverse reaction(s) to any dental procedures? If yes, please explain: ____________

____

Medical and Dental Health History

Medical History

How would you rate your child's current physical health? ☐Poor ☐Fair ☐Good Are immunizations current? ☐ Y ☐ N

Please list any medications and doses the child is taking ☐None ____

____

Please list any medications your child has a known allergy to: ____

☐Yes ☐No Has your child ever been hospitalized? If so, when?:___________ Explain:______________________________

☐Yes ☐No Has your child ever had surgery? If so when?:____________Explain: ______________________________

Does your child play sports? ☐Yes ☐No If yes, type: ____

Has your child ever had a history of the following? (Check all that apply) ☐ None

- ☐ADD/ADHD
- ☐Allergies
  - ☐Environmental
  - ☐Latex
  - ☐Nickel
  - ☐Dyes or flavorings? _________
  - ☐Tree nuts
  - ☐Other___________________
- ☐Anemia
- ☐Artificial bones/joints/valves
- ☐Asthma
- ☐Autism Spectrum
- ☐Behavior problems
- ☐Bleeding Disorder
- ☐Breathing/Lung problem
- ☐Congenital Birth Defect
- ☐Convulsions
- ☐Diabetes
- ☐Emotional Problems
- ☐Fainting
- ☐Frequent Infections
- ☐Growth problems
- ☐Headaches
- ☐Hearing Impairment
- ☐Heart Murmur
- ☐Heart Surgery
- ☐Heart Problem
- ☐Hepatitis
- ☐HIV/AIDS
- ☐Hives/rash
- ☐Kidney Disease
- ☐Learning Disabilities
- ☐Liver Disease
- ☐Low Birth Weight
- ☐Mental Impairment
- ☐Premature (How many weeks?_____)
- ☐Physical disability
- ☐Rheumatoid Arthritis
- ☐Rheumatic Fever
- ☐Scarlet Fever
- ☐Seizure disorder
- ☐Tuberculosis
- ☐Tumors/Cancer
- ☐Vision problems
- ☐ Additional Information: ______ ________________________ ________________________ ________________________

Is there anything additional you would like to discuss with the doctor in private? ☐ Yes ☐ No

Name of pediatrician: ________________________________ Pediatrician Contact Number: (_____) -______- _________

Signed: ____________________________Date:____________

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Reviewer Initials _______ Date: ____________