growing smiles
pediatric dentistry

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 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:_____

OFFICE USE ONLY

Reviewer Initials _____ Date: _____