PEDIATRIC DENTISTRY
MEDICAL HISTORY FORM

PATIENT IDENTIFICATION

DiRECTIONS: Please circle appropriate answers and fill in 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**	(?)
Rheumatic fever	YES	**NO**	(?)
Bleeding or clotting problems	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**	(?)
Mental retardation	YES	**NO**	(?)
Growth problems	YES	**NO**	(?)
Cerebral palsy	YES	**NO**	(?)
Ear or hearing problems	YES	**NO**	(?)
Speech difficulties	YES	**NO**	(?)
Vision Problems	YES	**NO**	(?)
Asthma or wheezing	YES	**NO**	(?)
Allergies (hay fever, latex sensitivity, etc.)	YES	**NO**	(?)
Feeding or eating disorders	YES	**NO**	(?)
Hepatitis or liver disease	YES	**NO**	(?)
Diabetes	YES	**NO**	(?)
Tuberculosis	YES	**NO**	(?)
Kidney problems	YES	**NO**	(?)
Bone or joint problems	YES	**NO**	(?)
Drug or alcohol use	YES	**NO**	(?)
Smoking or use of snuff or smokeless tobacco	YES	**NO**	(?)
Sexually transmitted or venereal disease (VD)	YES	**NO**	(?)
AIDS or AIDS-related complex	YES	**NO**	(?)
Cancer	YES	**NO**	(?)
Other medical problems (specify) _____	YES	**NO**	(?)
Name of patient's physician _____ Date of last visit _____	YES	**NO**	(?)
Address _____ Phone # _____	YES	**NO**	(?)
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 reaction to any medications			
To what _____ Reaction _____			
Has the patient ever been hospitalized?	YES	**NO**	(?)
Age _____ Reason _____			
Has the patient been treated in the emergency room?	YES	**NO**	(?)
Age _____ Reason _____			
Are the patient's immunizations up-to-date?	YES	**NO**	(?)
Is the patient pregnant at this time?	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 a dentist?	YES	**NO**	(?)
If no, give date of last visit _____			
Has the patient had any of the following dental problems?			
Injuries to mouth or teeth	YES	**NO**	(?)
Toothaches/pain	YES	**NO**	(?)
Abscesses (gum boils)	YES	**NO**	(?)
Other (specify) _____			
Does the patient have any of the following habits?			
Finger or thumb sucking	YES	**NO**	(?)
Tooth grinding or clenching	YES	**NO**	(?)
Other (specify) _____			
At what age was bottle or breast feeding stopped? _____			
What is the source of the patient's current drinking water supply?			
_____ City _____ Home well _____ Bottled _____ Don't know			
Is this water fluoridated?	**YES**	NO	(?)
Does patient receive fluoride tablets, drops or vitamins with fluoride?	YES	**NO**	(?)
Does the patient use a fluoride rinse at home or school?	YES	**NO**	(?)
Who is responsible for brushing the patient's teeth? _____			
Is there any additional dental information we should know?	YES	**NO**	(?)
If yes, describe _____			

SOCIAL & 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**	(?)
Which of the following best describes the patient?			
_____ Advanced in the learning process _____ Progressing normally _____ Slow learner			
Does the patient have any history of emotional or behavioral problems?	YES	**NO**	(?)
If yes, describe _____			
Are there any cultural, religious or ethnic concerns that could affect the care of your child?	YES	**NO**	(?)
If yes, describe _____			
Names and ages of other children in the family _____			
_____			
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 & summary: _____

_____

_____

_____

Updated _____ Reviewed by _____

Updated _____ Reviewed by _____

Updated _____ Reviewed by _____

Updated _____ Reviewed by _____

Updated _____ Reviewed by _____

Updated _____ Reviewed by _____