Pediatric Medical History

Patient's Name: _____ Date of Birth: _____

MEDICAL HISTORY

☐Yes ☐No Is your child being treated by a physician?
☐Yes ☐No Has your child been treated in the emergency room?
☐Yes ☐No **Has your child ever been hospitalized?**
If yes, for what, when? _____
☐Yes ☐No **Has your child ever had any surgeries?**
If yes, for what?_____
☐Yes ☐No **Is there an allergy to a medicine or latex gloves?**
If yes, what medicines? _____
☐Yes ☐No **Is your child taking a medication at this time?**
If yes, what? _____

Child's Physician/Pediatrician

Dr. _____

Physician's Phone # _____

Date of last visit_____

Has this child ever been diagnosed with any of the following conditions?

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Mental Retardation
☐	☐	Asthma	☐	☐	Pneumonia	☐	☐	Emotional Problems
☐	☐	Autism	☐	☐	Eye Problems	☐	☐	Rheumatic Fever
☐	☐	Behavioral Problems	☐	☐	Hearing Disorder	☐	☐	Scarlet Fever
☐	☐	**Bleeding Problems**	☐	☐	**Heart Murmur**	☐	☐	Sickle Cell
☐	☐	Brain Injury	☐	☐	Hepatitis	☐	☐	Speech Disorder
☐	☐	Cancer	☐	☐	HIV (AIDS)	☐	☐	Hyperactivity /ADHD
☐	☐	Leukemia	☐	☐	Whooping Cough	☐	☐	Tuberculosis
☐	☐	Developmentally Delayed	☐	☐	Measles	☐	☐	Other _____
☐	☐	Convulsions/Seizures/Epilepsy				☐	☐	Syndrome _____

DENTAL HISTORY

Yes	No	
☐	☐	Does your child brush regularly?
		Does your child use:
☐	☐	Fluoride vitamins?
☐	☐	Fluoride rinse/gel?
☐	☐	Fluoridated drinking water?

Yes	No	
☐	☐	Has your child been seen by a dentist before?
☐	☐	Has your child had any accidents involving his/her teeth?
☐	☐	Does your child have a dental condition that seems to "run in the family" (hereditary)? If so, please indicate: _____
☐	☐	Is there anything you would like to discuss personally with the dentist who examines your child?

Does this child do any of the following? ☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking
☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting

How do you expect your child to react to dental treatment?
☐ Very well ☐ Moderately well ☐Not well Why?_____

If your child has any pets, hobbies, or special interests, please list: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or heal practitioners.

_____ _____ _____
Signature of Parent or Guardian Date Reviewer