Pediatric Dental Care ☺

Child Dental And Medical History Patient Number _____

Patient's Name _____ Nickname _____
Last First

Parent or Guardian accompanying patient _____
Full Name

DENTAL HISTORY

1. Does your child eat between meals?----------YES/NO
2. Does your child eat sweets, such as candy, soda pop, chewing gum?----------YES/ NO
   How Often? ----------
3. When does you child brush his/her teeth?
   Upon arising Right after meals Before going to bed
4. Do you help your child with brushing his/her teeth? YES/NO
5. Does your child floss? YES/NO Do you help your child with flossing? YES/NO
6. What type of tooth paste does your child use? With or without Fluoride? (Please circle one)
7. How does your child receive other sources of Fluoride?
   a. Do you use "bottled water"? YES/NO With or without Fluoride? (Please circle one)
      If yes, do you use it for? 1) drinking, 2) cooking , or 3)Both
   b. Do you use community water (tap water) for: 1) drinking, 2) cooking , 3)Both, 4)Neither
   c. Do you filter your tap water? YES/NO
   d. If yes, does the filter remove the Fluoride? YES/NO/Don't know
   e. Are you on well water? YES/NO
   f. If yes, have you had the well water tested for Fluoride content? YES/NO
      (Fluoride level---------- ppm if applicable)
   g. Is your child taking any Fluoride drops or tablets? YES/NO (-------- mg/daily)
   h. Is your child using supplemental Fluoride rinse or gel? YES/NO
      Name of product ---------- How often Used? ----------
8. Have there been any injuries to your child's teeth, such as falls, blows, chips, etc, ----------YES/NO
   If so describe_____
9. Does your child think there is anything wrong with his/her teeth?----------YES/NO
10. Does your child report any tooth ache/ discomfort?----------YES/NO
    If yes, please explain _____
11. Does your child wear a mouth piece when playing sports?----------YES/NO
12. Any oral habits, such as: Thumb sucking, nail biting, grinding, clinching, bottle feeding? -----YES/NO
    If yes, please explain _____

MEDICAL HISTORY

1. Does your child currently have a health problem?----------YES/NO
   If yes, since when and what is the problem?_____
2. Name of physician:_____Phone #:_____
3. Is your child receiving any medication?----------YES/NO
   Name of medication(s) and dosages?_____
   _____

CHILD DENTAL AND MEDICAL HISTORY

4. Is your child allergic to antibiotics or other drugs?----------YES/NO
   What is the name of medication(s)? _____
5. Is your child allergic to or sensitive to latex?----------YES/NO
6. Does your child have any other allergies?---------- YES/NO
   Please describe: _____
7. Has your child had any recent serious illness or hospitalization?----------YES/NO
   When_____ What_____
8. Is your child suspected to nervous disorders?----------YES/NO
   Fainting? Seizures? Dizziness? Behavioral/Learning problem? Other?
   Please describe: _____
9. Does your child have frequent headaches?----------YES/NO
10. Does your child suffer from high/low blood pressure?----------YES/NO
11. Has your child have a history of (Circle appropriate responses) diabetes, **heart trouble**, Valvular replacements, pacemaker, **asthma**, kidney infection, **rheumatic fever**, artificial (prosthetic joints), epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, **infections**, speech impairments, hearing loss, pregnancy, developmental delays.
12. Other, please explain_____

_____

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

_____ _____
Signature of parent/guardian Date

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FOR DENTIST USE ONLY

Comments:

_____ _____
Signature of Dentist Date