CHILDREN'S MEDICAL - DENTAL HISTORY

Date_____

Child's name_____ Sex_____ Birth Date_____ Place of Birth_____

Child's Nickname_____ Chief complaint / Reason for visit_____

Mother's name_____ Father's name_____

Home Telephone_____ Home Telephone_____

Work Telephone_____ Work Telephone_____

Physician's Name _____ Date of Last Physical Exam_____

Physician's Address_____

MEDICAL HISTORY

GROWTH AND DEVELOPMENT Any learning, behavioral, excessive nervousness, mental retardation or communication problems?	No	Yes
Has child had psychological counseling or is counseling being considered for the near future?	No	Yes
Were there any complications during pregnancy or was child premature at birth?	No	Yes
Any problems with physical growth?	No	Yes
Congenital birth defects?	No	Yes
CENTRAL NERVOUS SYSTEM Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness?	No	Yes
Any history of injury to the head?	No	Yes
Recurrent headaches? If Yes, medications and dose taken_____	No	Yes
Does (or has) your child have (or had) difficulty opening his or her mouth, or does the child's jaw sometimes lock or stick in a certain position?	No	Yes
Does (or has) your child have (or had) popping clicking noises or pain during chewing or yawning?	No	Yes
Any sensory disorders? (Seeing, Hearing)	No	Yes
CARDIOVASCULAR SYSTEM Any history of congenital heart disease, heart murmur, or heart damage from rheumatic fever?	No	Yes
Has any heart surgery been done or recommended?	No	Yes
Any history of chest pains or high blood pressure?	No	Yes
HEMATOPOIETIC AND LYMPHATIC SYSTEMS Has your child ever had a blood transfusion or blood products transfusion? If Yes; Date _____	No	Yes
Any history of anemia or sickle cell disease?	No	Yes
Any history of cancer, tumors, or blood dyscrasias?	No	Yes
Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts?	No	Yes
Is your child more susceptible to infections than other children are?	No	Yes
Is there any history of tender or swollen lymph nodes or glands?	No	Yes
RESPIRATORY SYSTEM Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty in breathing?	No	Yes
GASTROINTESTINAL SYSTEM Any history of stomach, intestinal or liver problems?	No	Yes
Any history of hepatitis or jaundice?	No	Yes
Any history of eating disorders, such as anorexia nervosa (binge/purge) or bulimia (binge)?	No	Yes
Any history of unintentional weight loss?	No	Yes
GENITOURINARY SYSTEM Any history of urinary tract infections, bladder or kidney problems?	No	Yes
Is the patient pregnant or possibly pregnant?	No	Yes
ENDOCRINE SYSTEM Any history of diabetes?	No	Yes
Any history of thyroid disorders or other glandular disorders?	No	Yes
SKIN Any history of skin problems?	No	Yes
Any history of cold sores (herpes) or canker sores (aphthae)?	No	Yes
EXTREMITIES Any limitations of use of arms or legs?	No	Yes
Any arthritis or other joint problems?	No	Yes
Any problems with muscle weakness or muscular dystrophy?	No	Yes
ALLERGIES Is your child allergic to any medications?	No	Yes
Any hay fever, hives, or skin rashes caused by allergies?	No	Yes
Any other allergies?_____	No	Yes
ANY OTHER SIGNIFICANT PROBLEMS?_____	No	Yes

(OVER)

MEDICATIONS OR TREATMENTS Is your child currently taking any medication (prescription or non-prescription medicine)? No Yes

If yes, Medication(s) Dosage Times Per Day

_____ _____ _____

_____ _____ _____

_____ _____ _____

Has your child ever received radiation therapy (x-ray treatments) or is it planned? No Yes

Has your child ever received chemotherapy or is it planned? No Yes

HOSPITALIZATIONS

Has your child been hospitalized?

Hospital (1)_____ (2)_____ (3)_____

Date _____ _____ _____

Reason _____ _____ _____

IMMUNIZATIONS Is your child presently protected by immunization against DPT: diphtheria, whooping cough (pertussis), tetanus? No Yes

Polio (poliomyelitis)? No Yes

MMR: measles (rubeola), mumps, and German measles (rubella)? No Yes

Hepatitis B (Heptavax B) or pneumococcal vaccine (Pneumovax or Pnu-Imune)? No Yes

CHILDHOOD AND OTHER ILLNESSES Please check any of the following that your child has now, has recently been exposed to, or has had in the past:

	Now	Exposed	Past		Now	Exposed	Past
AIDS	___	_____	___	Chicken pox	___	_____	___
Earache	___	_____	___	Eye infection	___	_____	___
German measles	___	_____	___	Mononucleosis	___	_____	___
Measles (rubeola)	___	_____	___	Mumps	___	_____	___
Scarlet fever	___	_____	___	Venereal Disease	___	_____	___
Substance abuse alcoholism, drugs	___	_____	___	Upper Respiratory infection (URI)	___	_____	___

DENTAL HISTORY

Has your child ever had or have a toothache or other immediate dental problem? No Yes

Has your child had any injury to the mouth, teeth or jaws (fall, blow, etc.)? No Yes

Is this your child's first dental visit? If no : Date _____ Reason _____ No Yes

Has your child had dental x-rays? If Yes: Date of last x-rays _____ No Yes

Has your child ever had an unfavorable dental experience?_____ No Yes

Describe your child's personality/temperament _____

Is (was) your child nourished by nursing beyond one year of age? No Yes

If yes, check: Breast _____Nursing bottle _____ Both _____, and to what age? _____

Does your child fail to eat a well-balanced diet? No Yes

If yes, what foods or food groups are not adequate? _____

Does (or has) your child have (or had) sucking habit beyond one year of age? No Yes

If yes, check: Thumb(s) _____ Finger(s) _____ Pacifier _____ Other _____

Does (or has) your child have (or had) any other oral habits beyond one year of age? No Yes

If yes, check: Lip biting ___ Mouth breathing ___ Nail biting ___Teeth grinding ___ Other ___

DENTAL DISEASE PREVENTION

How often does your child brush? _____ times per _____ Does your child use dental floss? No Yes

Does someone assist your child with brushing and cleaning the teeth? No Yes

Does someone inspect for thoroughness after the procedure? No Yes

Does your child use a fluoride toothpaste? No Yes

Has your child ever had a fluoride treatment? No Yes

Has your child ever taken a fluoride supplement or vitamins with fluorides? No Yes

Drinking water source: City water ___ Name of city _____ Private well ___ Other _____

Has a fluoride analysis been done? _____ Date of analysis _____

UPDATE OF MEDICAL HISTORY

Date	Significant Findings	Signature/Initial
_____	_____	_____
_____	_____	_____
_____	_____	_____