Time 11:14 AM | Katahdin Pediatric Dentistry | Date 1/15/2021

MEDICAL/DENTAL HISTORY UPDATE

Patient Name: | Birth Date: | Date Created:

MEDICAL

What is your primary concern regarding your child's oral health?	◯ Yes ◯ No	If yes	
Is your child being treated by a physician at this time? Reason	◯ Yes ◯ No	If yes	
Has your child had any illness, surgery,injury,medical emergency,in the past year? Describe	◯ Yes ◯ No	If yes	
Has your child ever had a reaction to or problems with an anesthetic? Describe	◯ Yes ◯ No	If yes	

Has you child ever had a reaction or allergy to an antibiotic, sedative, or other medication?

Antibiotic	◯ Yes ◯ No
Sedative	◯ Yes ◯ No
Other medication	◯ Yes ◯ No

Is your child taking any medication?(prescription, over the counter, vitamins, or dietary supplement)

Medication	◯ Yes ◯ No
Over the counter	◯ Yes ◯ No
Dietary supplement	◯ Yes ◯ No

What medication is your child taking ? why and how much?	◯ Yes ◯ No	If yes	
Is your child allergic to latex or anything else such as metal, acrylic, or dye?	◯ Yes ◯ No	If yes	

DENTAL HISTORY

Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office?	◯ Yes ◯ No	If yes	
Has your child's diet changed significantly since his/her last dental visit? Describe	◯ Yes ◯ No	If yes	
Has your child been treated by another dentist/dental professional since last visitng our office? Reason and what	◯ Yes ◯ No	If yes	
Is ther any other change in the child's medical, dental, or family history that the dentist should be told?	◯ Yes ◯ No	If yes	

I certified that the answers for these question are acurate to the best of my knowledge.

Signature of Patient, Parent or Guardian:

X

Date:_____