PEDIATRIC Medical History 2020

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around the mouth, yourchild's mouth is a part of his/her entire body. Health problems that he/she may have, or medication that he/she ma

Question	Answer	
Is your child being treated by a physician now?	Yes No	If yes
Have your child ever been hospitalized, had surgery or been treated in an emergy department?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Has your child ever had a reaction to or problem with an anesthetic? Describe	Yes No	If yes
Has your child ever had a reaction or allergy to an antiotic, sedative, or other medication?	Yes No	If yes
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List	Yes No	If yes
Is your child up to date on immunization agianst childwood diseases?	Yes No	
Does your child have any special need?	Yes No	If yes
Do you have any additional concern for your child?	Yes No	If yes

Any allergies to any of the following?

Aspirine	Yes No	Penicillin	Yes No	Codeine	Yes No	Sedative Medication	Yes No
Metal	Yes No	Latex	Yes No	Sulfa Drugs	Yes No	Local Anesthetics	Yes No
Other not listed	Yes No						

Age appropriate quastion , ask these question to parents or selective patients:

Any smoker aound you?	Yes No	Taking oral contraceptives?	Yes No	Electronic cigarette	Yes No
Alcohol orrecreational drug	Yes No	Sexual activities	Yes No	Abuse	Yes No
Anxiety, depression,helpless	Yes No	Possible pregnant	Yes No	Eating disorder	Yes No
Breastfed	Yes No	Any Bottle to bed	Yes No	Brusing/flossing	Yes No
Any sibblings	Yes No	Teething problem	Yes No	Anything else	Yes No

Complications before or during birth, prematurity, birth defects, syndroms, or inherited conditions	Yes No	If yes
Problems with physical growth or development	Yes No	If yes

Does your child have, or has he/she had, any of the following?

Complications before or during birth, syndromes?	Yes No	Cortisone Medicne	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Sleep apnea/snoring, mouth breading,excessive gagging	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Reactive airway, breathing problem	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma, Lung Disease	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough, cold or pneumonia	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease, Jaundice, Hepatitis	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Frequent tobaco exposure	Yes No	Cystic Fibrosis	Yes No	GERD,Stomach issues	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis, Chronic adenoid/tonsil infection	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Defect/ Disease	Yes No	Psychiatric Care	Yes No	Parathyroid Disease	Yes No	Heart Pacemaker, Rhumatic fever, Irregular heat beat	Yes No
Convulsions	Yes No	Excessive Thirst	Yes No	High blood pressure	Yes No	Yellow Jaundice	Yes No
Autism Spectrum	Yes No	ADD/ADHD	Yes No	Impaire vision, speech	Yes No		

Have you ever had any serious illness not listed above?	Yes No	If yes

Pleae check appropriately and justify for any yes

Mouth sore or feverblister	Yes No	Bad Breath	Yes No	Bleeding gums	Yes No
Cavities/decayed tooth	Yes No	Toothache	Yes No	Clinching/grinding teeth	Yes No
Jawjoint problems	Yes No	Excessive gagging	Yes No	Non nutritive sucking habit	Yes No
Brushe teeth at least 2 times	Yes No	Use fluoride toothpaste	Yes No	Fluoride contained water	Yes No
Any special diet	Yes No	Mouth rinse	Yes No	Excess candy, sweet, soft drinks...	Yes No
Any other dietary habit	Yes No	Any difficulty in dental care	Yes No	Any Xray taken before	Yes No
Any treatment by other	Yes No	Your child will do well	Yes No	Any ortho/spacer/appliance	Yes No
Any Sport	Yes No	Pacifier	Yes No	mouthguard/seatbelt/helmet	Yes No

Do you have any additional information	Yes No	If yes

Remarks

Do you have any question Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (child's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:___________