# DENTAL/MEDICAL HEALTH HISTORY

Smile PEDIATRICS

## PATIENT INFORMATION

Patient Last Name: _____First Name: _____M.I. ____

Nickname: _____ Gender: ☐ Male ☐Female Birth Date: ____/____/_____

## DENTAL HISTORY

What is the primary reason for today's visit? _____

Is your child currently having problems with any of the following?

☐ Cavities ☐ Toothache ☐ Sensitive Teeth ☐ Trauma ☐ Gum Infection ☐ Color of Teeth ☐ Tooth Alignment ☐ Other

Has the child experienced problems with previous dental work, including allergies or reactions to dental materials? ☐ Yes ☐ No

If yes, Explain: _____

Does the child brush his/her teeth daily? ☐ Yes ☐ No Does the child floss his/her teeth daily? ☐ Yes ☐ No

Do you give the child any other form of fluoride besides toothpaste? ☐ Yes ☐ No If yes, what? _____

Previous/Dentist: _____ Date of last visit: _____

## MEDICAL HISTORY

Child's Physician: _____ Medical Group / Practice: _____

Phone #: (_____)_____ Date of last visit: _____ Are immunizations current? ☐ Yes ☐ No

Please describe the child's current overall physical health: ☐ Good ☐ Fair ☐ Poor

Has the child been diagnosed with or treated for any of the following:

| | | | |
|---|---|---|---|
| ☐ Abnormal Bleeding | ☐ Blood Transfusion | ☐ Ear Infections / Aches | ☐ Hepatitis |
| ☐ AIDS/HIV | ☐ Blood Pressure High/Low | ☐ Epilepsy / Convulsions | ☐ Kidney/ Liver Problems |
| ☐ Allergies /Allergic to Latex | ☐ Brain Injury | ☐ Endocrine Disorders | ☐ Premature Birth |
| ☐ Anemia | ☐ Cancer | ☐ Handicaps/Disabilities | ☐ Psychiatric Problems |
| ☐ Asthma | ☐ Cerebral Palsy | ☐ Hearing Impairment | ☐ Rheumatic/Scarlet Fever |
| ☐ ADD or ADHD | ☐ Cleft Palate / Lip | ☐ Heart problems of any kind | ☐ Spina Bifida |
| ☐ Autism Spectrum Disorder | ☐ Diabetes | ☐ Hemophilia | ☐ Tuberculosis (TB) |

☐ Other _____

Has the child ever been admitted into the hospital or have they had any past operations? ☐ Yes ☐ No

If yes, Explain why and when: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No Please explain: _____

Please list all drugs that the child is currently taking: _____

Has your child ever had an unusual reaction or allergy to any of the following drugs? Please check all that apply:

☐ Penicillin ☐ Aspirin ☐ Acetaminophen ☐ Ibuprofen ☐ Codeine ☐ Sulfa Drugs ☐ Other _____

Does the child have any other known allergies of any kind? ☐ Yes ☐ No If yes, Explain: _____

Anything you would like to discuss with the Doctor in private today? ☐ Yes ☐ No

## PARENT SIGNATURE

I affirm that the information that I have given is correct to the best of my knowledge, that it well be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature: _____ Date: ____/____/____

## Doctor Notes

Reviewed:____/____/ ____ By: _____


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