Medical and Dental History Questionnaire

To provide the safest and most comprehensive dental care for your child, we ask for your cooperation in completing our detailed form.

Child's Last Name: ______ First Name: ______ MI: ______

Nickname/Preferred Name: ______ Sex: ______ Age: ______

Birthday: *Month* __ __ . *Day* __ __ . *Year* __ __ __ __

Child's Soc. Sec. #: ______ Home Phone #: (   ) ______

Child's home address: ______

City: ______ Zip: ______

Primary language spoken: ______ Child primarily lives with: ______

Siblings: *1. Name* ______ *1. Age,* ______ *2. Name* ______ *2. Age,* ______ *3. Name* ______ *3. Age,* ______

4. Name ______ *4. Age,* ______ *5. Name* ______ *5. Age,* ______ *6. Name* ______ *6. Age* ______

Name of pediatrician: ______ Phone #: ______

Date of last exam: ______ Reason: ______

Date of last dental visit: ______ Reason : ______

Medical History

Does your child have any medical conditions associated with the following?

- ☐ Yes ☐ No Cardiovascular: heart conditions
- ☐ Yes ☐ No Bleeding disorders
- ☐ Yes ☐ No Kidney disease
- ☐ Yes ☐ No Cerebral Palsy, Epilepsy, Febrile Seizures
- ☐ Yes ☐ No Asthma: ☐ *Mild* ☐ *Moderate* ☐ *Severe*
- ☐ Yes ☐ No Endocrine: ☐ *Diabetes* ☐ *Thyroid disorder* ☐ *Other*
- ☐ Yes ☐ No Liver disorder
- ☐ Yes ☐ No Viral/bacterial condition: ☐ *Hepatitis* ☐ *HIV/AIDS* ☐ *Tuberculosis* ☐ *Other*
- ☐ Yes ☐ No Eating disorder
- ☐ Yes ☐ No Bone or joint problems
- ☐ Yes ☐ No Psychiatric condition

☐ Yes ☐ No ADHD/ADD

☐ Yes ☐ No Autism

☐ Yes ☐ No Speech delay

☐ Yes ☐ No Premature birth ☐ *Low birth weight*

☐ Yes ☐ No Birth Defect/Genetic Disorder/Syndrome

☐ Yes ☐ No Cancer/Tumor ☐ *Chemotherapy/Radiation*

☐ Yes ☐ No *Young adult females/teenagers:* Any possibility you might be pregnant

☐ Yes ☐ No Has your child been hospitalized in the past?

Date .... *Reason* ....

☐ Yes ☐ No Past Surgeries: *please specify* ....

☐ Yes ☐ No Current medications: *please list* ....

☐ Yes ☐ No Any history of complications with sedation or general anesthesia?

☐ Yes ☐ No Is your child allergic to latex or any medications?

☐ Yes ☐ No Any other allergies? ....

☐ Yes ☐ No Any other medical conditions ....

☐ Yes ☐ No Are your child's immunizations up to date?

Dental History

☐ Yes ☐ No Has your child seen a dentist before?

How do you think your child will act toward the dentist? ....

What is your child most interested in? ☐ *toys* ☐ *pets* ☐ *dolls* ☐ *hobbies*

How often does your child brush his/her teeth? ....

☐ Yes ☐ No Is dental floss used?

☐ Yes ☐ No Has your child had any unfavorable experience in a dental office?

☐ Yes ☐ No Does your child participate in contact sports?

☐ Yes ☐ No Does your child use a mouth guard?

☐ Yes ☐ No Does your child have any history of dental trauma?

☐ Yes ☐ No *Toddlers and younger:* Does your child use a baby bottle or a sippy cup?

☐ Yes ☐ No Is your child breastfed?

☐ Yes ☐ No Does your child use a pacifier?

☐ Yes ☐ No Does your child have a habit of sucking his/her thumb?

☐ Yes ☐ No Does your child grind his/her teeth?

☐ Yes ☐ No Any other dental history/conditions ....

Signature .... Date .... 20 ....

Relationship to the child ....