



Pediatric Medical and Dental History

Wild About Smiles
Perry Francis DDS
www.waskids.com

PATIENT'S FULL NAME				PREFERRED NAME (OPTIONAL)		BIRTHDATE (mm/dd/yyyy)	
GENDER MALE FEMALE		Race/Ethnicity	HEIGHT	WEIGHT	NAME OF PERSON FILLING OUT THIS FORM		RELATIONSHIP TO PATIENT
NAME OF PRIMARY CARE PHYSICIAN			PHYSICIAN PHONE (xxx-xxx-xxxx)		NAME OF MEDICAL SPECIALIST (IF APPLICABLE)		SPECIALIST PHONE

Is your child being treated by a physician at this time? If yes please explain:	YES	NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? If yes please list name, dose, & date started:	YES	NO
Has your child ever been hospitalized, had surgery or a significant injury? If yes please list year and describe:	YES	NO
Has your child ever had a reaction to or problem with an anesthetic? Describe:	YES	NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? If yes please list and describe:	YES	NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List:	YES	NO
Is your child up to date on immunizations against childhood diseases?	YES	NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of the list. Mark NO after each line if none of these conditions apply to your child.

Complications before or during birth, prematurity, birth defects, syndromes or inherited conditions	YES	NO
Problems with physical growth or development	YES	NO
Sinusitis, chronic adenoid/tonsil infections	YES	NO
Sleep apnea/snorting, mouth breathing, or excessive gagging	YES	NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	YES	NO
Irregular heart beat or high blood pressure	YES	NO
Asthma, reactive airway disease, wheezing, or breathing problems	YES	NO
Cystic fibrosis	YES	NO
Frequent colds or coughs, or pneumonia	YES	NO
Frequent exposure to tobacco smoke	YES	NO
Gastrointestinal problems such as jaundice, hepatitis, liver problems, acid reflux disease, etc.	YES	NO
Lactose intolerance, nutritional deficiencies, dietary restrictions, concerns with weight or eating disorder	YES	NO
Food allergies. If YES, list:	YES	NO
Bladder or kidney problems	YES	NO
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems	YES	NO
Rash/hives, eczema or skin problems	YES	NO
Impaired vision, hearing, or speech	YES	NO
Developmental disorders, learning problems/delays, or intellectual disability	YES	NO
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures	YES	NO
Autism/autism spectrum disorder	YES	NO
Recurrent or frequent headaches/migraines, fainting, or dizziness	YES	NO
Hydrocephaly or placement of shunt	YES	NO
Attention deficit/hyperactivity disorder (ADD/ADHD)	YES	NO
Behavioral, emotional, communications, or psychiatric problems/treatment	YES	NO
Abuse (physical, psychological, emotional, or sexual) or neglect	YES	NO
Diabetes, hyperglycemia, hypoglycemia, precocious puberty, hormone problems, thyroid or pituitary problems	YES	NO
Blood disorders such as; anemia, sickle cell, hemophilia, excessive bleeding, blood transfusions	YES	NO
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow/organ transplant	YES	NO
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted infections (STI), or human immunodeficiency virus (HIV)/AIDS	YES	NO

PROVIDE DETAILS HERE:

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? If yes please explain:	YES	NO
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What is your primary concerns or thoughts about your child's oral health? Describe:

How would you describe:

your child's oral health?	Excellent	Good	Fair	Poor			
your oral health?	Excellent	Good	Fair	Poor			
oral health of your other children?	Excellent	Good	Fair	Poor			
Is there a family history of cavities?	YES	NO	If yes, indicate all that apply:	Mother	Father	Brother	Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	YES	NO		
Mouth sores or fever blisters	YES	NO		
Bad Breath	YES	NO		
Bleeding gums	YES	NO		
Cavities/decayed teeth	YES	NO		
Toothache	YES	NO		
Injury to teeth, mouth or jaws	YES	NO		
Clinching/grinding her/her teeth	YES	NO		
Jaw joint problems (popping, etc)	YES	NO		
Excessive gagging	YES	NO		
Sucking habit after one year of age	YES	NO	If yes, which: Finger Thumb Pacifier Other For how long?	
How often does your child brush his/her teeth?	times per		Does someone help your child brush? YES NO	
How often does your child floss his/her teeth?	Never	Sometimes	Daily	Does someone help your child floss? YES NO
What type of toothbrush does your child use?	Hard		Medium Soft Unsure	
What toothpaste does your child use?:			Do you use a water filter at home? YES NO	
What is the source of your drinking water at home?	City/community supply		Private well Bottled water Other	

Please check all sources of fluoride you child receives:

Drinking Water	Toothpaste	Over-the-counter rinse	Prescription rinse/gel	Prescription drops/tablets/vitamins
Fluoride treatment in the dental office		Fluoride varnish by pediatrician/other practitioner		Other:

For each YES response, please describe:

Does your child regularly eat 3 meals each day?	YES	NO
Is your child on a special or restricted diet?	YES	NO
Is your child a 'picky eater'?	YES	NO
Does your child have a diet high in sugars or starches?	YES	NO
Do you have any concerns regarding your child's weight?	YES	NO

How frequently does your child have the following?:

Candy or other sweets	Rarely	1-2 times/day	3 or more times/day	<u>Product:</u>
Chewing gum	Rarely	1-2 times/day	3 or more times/day	<u>Type:</u>
Snacks between meals	Rarely	1-2 times/day	3 or more times/day	<u>Usual Snack:</u>
Soft drinks*	Rarely	1-2 times/day	3 or more times/day	<u>Product:</u>

(* such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits:

Does your child participate in any sports	YES	NO	If YES, list:
Does your child wear a mouthguard during these activities?	YES	NO	If YES, What Type:

Has your child been examined or treated by another dentist? YES NO

If YES: Date of first visit:	Date of last visit:	Reason for last visit:		
Were x-rays taken of the teeth or jaw?	YES	NO	Date of most recent dental x-rays:	
Has your child ever had orthodontic treatment (braces, spacers, or other appliances)?	YES	NO	If YES, when?	
Has your child ever had a difficult dental appointment?	YES	NO	If YES, describe?	
How do you expect your child will respond to dental treatment?	Very well	Fairly well	Somewhat poorly	Very poorly
Is there anything else we should know before treating your child?	YES	NO	If YES, describe?	
SIGNATURE:	DATE	RELATIONSHIP TO PATIENT		



Pediatric Medical and Dental History Supplemental

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QUESTIONS FOR AN INFANT/TODDLER (1-3 YEARS OR AGE)						
Was your child born prematurely?	YES	NO	If YES, what week?			
What was your child's birth weight?	LB	OZ	Child's age (in months) when first tooth appeared in mouth:			
How long was your child breast-fed?	N/A	Less than 6 months	6-11 months	12-17 months	18-23 months	2 years or more
How long was your child bottle-fed?	N/A	Less than 6 months	6-11 months	12-17 months	18-23 months	2 years or more
Inherited dental characteristics	YES	NO	If YES, What type (check one)	Ready to use	Powdered	Liquid Concentrate
Does/did your child sleep with a bottle?	YES	NO	If YES, content of bottle?			
Does/did your child use a no-spill training cup (sippy cup)?	YES	NO	Has your child experienced any teething problems?		YES	NO
When did you start brushing his/her teeth?	N/A	Before 6 months	6-11 months	12-17 months	18-23 months	2 years or more
When did you begin using toothpaste?	N/A	Before 6 months	6-11 months	12-17 months	18-23 months	2 years or more
Who is your child's primary care taker during the day?			Who is your child's primary care taker during the evening?			
Name/Age of siblings at home:						
SIGNATURE:			DATE		RELATIONSHIP TO PATIENT	

QUESTIONS FOR AN ADOLESCENT PATIENT (TO BE COMPLETED BY THE PATIENT) (Ages 13 and Up)			
Do you have any concerns about your mouth, teeth, or oral health?	YES	NO	If YES, Describe?
Have you recently experienced any dental/oral pain?	YES	NO	If YES, Describe?
Do you bleach your teeth?	YES	NO	If YES, how often?
Have there been any recent changes in your dietary habits?	YES	NO	If YES, Describe?
Are you taking any dietary or herbal supplements?	YES	NO	If YES, Describe?
Do you participate in contact sports or high speed sports (skiing, motorcycles)?	YES	NO	If YES, Describe?
<p>We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.</p>			
Do you have any history of:			
Oral habits (chewing fingernails, clenching/grinding teeth, etc.)	YES	NO	PREFER NOT TO ANSWER
Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.)	YES	NO	PREFER NOT TO ANSWER
Eating disorder (anorexia, bulimia, etc.)	YES	NO	PREFER NOT TO ANSWER
Oral piercings/jewelry (including grill)	YES	NO	PREFER NOT TO ANSWER
Alcohol or recreational drug use/prescription abuse	YES	NO	PREFER NOT TO ANSWER
Inhalant use/abuse (such as huffing)	YES	NO	PREFER NOT TO ANSWER
Females: Are you pregnant or possibly pregnant?	YES	NO	
Is there anything you would like to discuss confidentially with your dentist?	YES	NO	
Would you like to discuss a referral to a family dentist or general dentist because of your age?	YES	NO	