Mountain Kids Pediatric Dentistry

Medical History

Child's Name:_____
Last *First* *Date of Birth* *Age*

Is your child presently under the care of a physician for any reason?

☐ No ☐ Yes- Explain:_____
Physician's Name *Phone*

Is your child taking any medications?

☐ No ☐ Yes-*Please list medications*: _____

Has your child ever been hospitalized, sedated, and/or undergone surgery?

☐ No ☐ Yes- Explain: _____

Does your child have any allergies to medications, latex, foods, etc.?

☐ No ☐ Yes- Explain: _____

Are antibiotics necessary for dental work because of heart defect, prosthesis, shunt, organ transplant or other medical reason?

☐ No ☐ Yes – Explain: _____

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

If your child has or ever had any of the following conditions, please check "Yes" below. Please explain any conditions to the doctor.

Yes	No	Condition	Yes	No	Condition
☐	☐	ADD/ADHD	☐	☐	Epilepsy/Seizure Disorder
☐	☐	AIDS/HIV	☐	☐	Eye Conditions/Visual impairment
☐	☐	Asthma	☐	☐	Females: Are you pregnant?
☐	☐	Autism Spectrum/Asperger's Syndrome	☐	☐	Females: Are you taking birth control?
☐	☐	Behavioral Problems	☐	☐	Genetic Syndromes/Disorders?
☐	☐	Birth Defects	☐	☐	GI disorder
☐	☐	Blood Transfusions	☐	☐	Hearing Impairment
☐	☐	Bone, Joint or Muscle Problems	☐	☐	Heart Disease/Surgery
☐	☐	Brain Injury	☐	☐	Heart Murmur
☐	☐	Cerebral Palsy	☐	☐	Hemophilia/Bleeding disorders
☐	☐	Cancer/Tumor	☐	☐	Hepatitis/Liver Disease
☐	☐	Chemical dependency	☐	☐	Kidney Disease
☐	☐	Chemotherapy/Radiation	☐	☐	Metabolic Disorder
☐	☐	Chicken Pox	☐	☐	Metallic Implant, Shunts, Pins
☐	☐	Child Abuse	☐	☐	Premature Birth
☐	☐	Chronic Respiratory Disease	☐	☐	Psychiatric Care
☐	☐	Cleft Lip/Palate	☐	☐	Reflux
☐	☐	Cold Sores/Canker Sores	☐	☐	Seasonal/Environmental allergies
☐	☐	Developmentally Delayed (Age Level___)	☐	☐	Sickle Cell Anemia
☐	☐	Diabetes (Type____)	☐	☐	Speech Impairment
☐	☐	Eating Disorder	☐	☐	Tonsillitis
			☐	☐	Transplants, Organ (specify_____)

Is there any other health information that should be known?

☐ No ☐ Yes – Explain: _____

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Dental History

Who may we thank for referring your family? _____

Is this your child's first dental visit? ☐ Yes ☐ No _____
Previous dentist *Date of Last Visit* *Date of last x-rays*

Has your child experienced any unfavorable reaction from previous dental or medical care?
☐ No ☐ Yes- Explain: _____

Have there been any injuries to your child's teeth or jaws?
☐ No ☐ Yes- Explain: _____

Has your child had recent dental pain?
☐ No ☐ Yes- Explain: _____

Does your child have a specific dental problem that needs attention?
☐ No ☐ Yes- Explain: _____

Does any member of the family have decay or fillings?
☐ No ☐ Yes- Explain: _____

Oral Habits

How often does your child brush? _____
Is fluoride toothpaste used? ☐ No ☐ Yes Is dental floss used? ☐ No ☐ Yes
Is tooth brushing supervised? ☐ No ☐ Yes Does a parent do the brushing? ☐ No ☐ Yes

Please check all that apply and circle those habits which are currently ongoing
☐ Breast feeding ☐ Thumb sucking ☐ Bottle habits ☐ Pacifier ☐ Sippy cup

Does your child take a bottle or a cup to bed? ☐ No ☐ Yes

What does your child drink throughout the day? _____

What does your child eat for snacks? _____

Does your child receive: (check all that apply)
☐ Tap water ☐ Well water ☐ Bottled water ☐ Fluoride rinse ☐ Fluoride tablets/drops