MEDICAL HISTORY

• SOUTHERN ILLINOIS • Pediatric Dentistry OF EDWARDSVILLE

Child's Full Name: _____ Nickname: _____ Date of birth: _____/_____/_____

Gender: □ M □ F Height : _____ Weight: _____ Date of last physical exam: _____/_____/_____

Name/address/phone of primary physician: _____

Name/address/phone of medical specialists:_____

Is your child being treated by a physician at this time? Reason _____ □ YES □ NO

Is your child taking any medications (prescription or over the counter), vitamins, or supplements? □ YES □ NO

List name, dose, frequency & date started: _____

_____

Has your child ever been hospitalized, had surgery, or been treated in the ER? □ YES □ NO

List date & describe: _____

Has your child ever had a problem with an anesthetic? Describe:_____ □ YES □ NO

Has your child ever had a reaction or allergy to an antibiotic or medication? List: _____ □ YES □ NO

Is your child allergic to latex or anything else such as metals, acrylic, etc.? List: _____ □ YES □ NO

Is your child up to date on immunizations against childhood diseases? □ YES □ NO

Please mark YES or NO for the following medical conditions:

Abnormal bleeding/Hemophilia	□ YES □ NO	Heart Murmur	□ YES □ NO
Anemia	□ YES □ NO	Hepatitis / Liver Problems	□ YES □ NO
Asthma	□ YES □ NO	Hydrocephaly / Shunt Placement	□ YES □ NO
Autism	□ YES □ NO	Hypertension	□ YES □ NO
Complications at birth	□ YES □ NO	HIV/ AIDS	□ YES □ NO
Cancer	□ YES □ NO	Kidney / Bladder Problems	□ YES □ NO
Congenital Heart Defects	□ YES □ NO	Neurological Disorders	□ YES □ NO
Cystic Fibrosis	□ YES □ NO	Pneumonia	□ YES □ NO
Developmental Disorders	□ YES □ NO	Seizures	□ YES □ NO
Gastroesophageal / Acid Reflex	□ YES □ NO	Sinus Problems	□ YES □ NO

Please list any other significant medical history pertaining to this child or his/her family that the dentist should be told:

_____

_____

Dental History

Has your child ever been to the dentist? □ YES □ NO

Has your child ever had a bad experience at the dentist? Explain: _____ □ YES □ NO

Has your child ever had a thumb/finger sucking habit? □ YES □ NO

Do you help your child brush and floss? □ YES □ NO

Does your child use a mouth rinse? What kind: _____ □ YES □ NO

Does your child brush with fluoridated toothpaste? How often: _____ □ YES □ NO

Does your child floss? How often: _____ □ YES □ NO

Please check if your child is having any problems with any of the following:

□ Cavities □ Toothache □ Sensitive Teeth □ Trauma □ Gum Infections

□ Color of Teeth □ Orthodontics □ Jaw Sounds □ Other

Parent or Legal Guardian's Signature Date