MEDICAL-DENTAL HISTORY

Valley Pediatric Dental

Date _____

Child's name _____ Sex _____ Birth date _____ Place of birth_____

Date of last medical examination _____ Child's physician/ pediatrician _____ Telephone _____

Physicians address _____

MEDICAL HISTORY

GROWTH AND DEVELOPMENT:

Any learning, behavioral, excessive nervousness, or communication problems? No ( ) Yes ( )
Has child had psychological counseling or is counseling being considered for the near future? No ( ) Yes ( )
Were there any complications during pregnancy or was child premature at birth? No ( ) Yes ( )

CENTRAL NERVOUS SYSTEM:

Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness? No ( ) Yes ( )
Any history of injury to the head? No ( ) Yes ( )
Any sensory disorders? (Seeing, Hearing) No ( ) Yes ( )

CARDIOVASCULAR SYSTEM:

Any history of congenital heart disease, heart murmur, or heart damage from rheumatic fever? No ( ) Yes ( )
Has any heart surgery been done or recommended? No ( ) Yes ( )
Any history of chest pains or high blood pressure? No ( ) Yes ( )

HEMATOPOIETIC AND LYMPHATIC SYSTEMS:

Has your child ever had a blood transfusion or blood products transfusion? No ( ) Yes ( )
Any history of anemia or sickle cell disease? No ( ) Yes ( )
Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts? No ( ) Yes ( )
Is your child more susceptible to infections than other children are? No ( ) Yes ( )
Is there any history of tender or swollen lymph nodes or glands? No ( ) Yes ( )

RESPIRATORY SYSTEM:

Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty in breathing? No ( ) Yes ( )

GASTROINTESTINAL SYSTEM:

Any history of stomach, intestinal or liver problems? No ( ) Yes ( )
Any history of hepatitis or jaundice? No ( ) Yes ( )
Any history of eating disorders, such as anorexia nervosa (binge) or bulimia (binge/purge)? No ( ) Yes ( )
Any history of unintentional weight loss? No ( ) Yes ( )

GENITOURINARY SYSTEM:

Any history of urinary tract infections, bladder or kidney problems? No ( ) Yes ( )
Is the patient pregnant or possibly pregnant? No ( ) Yes ( )

ENDOCRINE SYSTEM:

Any history of diabetes? No ( ) Yes ( )
Any history of thyroid disorders or other glandular disorders? No ( ) Yes ( )

SKIN:

Any history of skin problems? No ( ) Yes ( )
Any history of cold sores (herpes) or canker sores (aphthae)? No ( ) Yes ( )

EXTREMITIES:

Any limitations of use of arms or legs? No ( ) Yes ( )
Any arthritis, joint bleeding, joint replacements, or other joint problems? No ( ) Yes ( )
Any problems with muscle weakness or muscular dystrophy? No ( ) Yes ( )

ALLERGIES:

Is your child allergic to any medications? No ( ) Yes ( )
Any hay fever, hives, or skin rashes caused by allergies? No ( ) Yes ( )
Any other allergies? No ( ) Yes ( )

MEDICATIONS AND TREATMENTS:

Is your child currently taking any medication (prescription or non-prescription medicine)? No ( ) Yes ( )

If yes, Medication(s)	Dosage	Time Per Day

Has your child ever received therapy (x-ray treatments) or is it planned? No ( ) Yes ( )
Has your child ever received chemotherapy or is it planned? No ( ) Yes ( )

Hospitalizations

Has your child been hospitalized? No ( ) Yes ( )

	(1)	(2)	(3)
Hospital			
Date			
Reason			

IMMUNIZATIONS:

Is your child presently protected by Immunization against **DPT**: diphtheria, whooping cough (pertussis), tetanus? **No ( ) Yes ( )**
OPV: polio or poliomyelitis? **No ( ) Yes ( )**
MMR: measles (rubeola), mumps, and German measles (rubella)? **No ( ) Yes ( )**
Hib (Haemophilus b vaccine)? **No ( ) Yes ( )**
Pneumococcal vaccine? **No ( ) Yes ( )**
Hepatitus B vaccine? **No ( ) Yes ( )**

		Now	Exposed	Past
❖ **PLEASE CHECK ANY OF THE ILLNESSES THAT YOUR CHILD HAS NOW, HAS RECENTLY BEEN EXPOSED TO, OR HAS HAD IN THE PAST:**	❖ Chicken pox (varicella)			
	❖ Earache (otitis)			
	❖ Eye infection (conjunctivitis)			
	❖ German measles or 3-day measles (rubella)			
	❖ Glandular fever or mono (infectious mononucleosis)			
	❖ HIV/AIDS			
	❖ Lead poisoning			
	❖ Measles (rubella)			
	❖ Mumps (parotitis)			
	❖ Scarlet fever (scartatina)			
	❖ Sore throat (tonsillitis or pharyngitis)			
	❖ Substance abuse, alcoholism, drug addiction			
	❖ Tuberculosis			
❖Upper respiratory infection (URI), or common cold (pharyngitis, rhinitis, sinusitis, or tonsillitis)				
❖Venereal disease (genital herpes, gonorrhea, syphilis or other)				

DENTAL HISTORY

Does your child have a toothache or other immediate dental problem? No ( ) Yes( )
Has your child ever had a toothache? No ( ) Yes( )
Has your child had any injury to the mouth, teeth or jaws (fall, blow, etc.)? No ( ) Yes ( )
Is this your child's first dental visit? If no: No ( ) Yes ( )
Date: Dentist: Reason:
Has your child ever had an unfavorable dental experience? No ( ) Yes ( )
Is (was) your child nourished by nursing beyond one year of age? If yes: No ( ) Yes ( )
Check: Breast_____ Nursing bottle_____ Both _____, and to what age?_____
Does your child fail to eat a well-balanced diet? If yes, what foods or food groups are not adequate? No ( ) Yes ( )
_____
Does (or has) your child have (or had) sucking habit beyond one year of age? If yes, No ( ) Yes ( )
Check: Thumb(s) _____ Finger(s) _____ Pacifier _____ Other:_____
Does (or has) your child have (or had) any other oral habits beyond one year of age? If yes, No ( ) Yes ( )
Check: Lip biting ___ Mouth breathing ___ Nail biting ___ Teeth grinding ___ Other _____
Does (or has) your child have (or had) difficulty opening his or her mouth, or does the child's jaw sometimes lock or stick in a certain position? No ( ) Yes ( )
Does (or has) your child have (or had) popping or clicking noises or pain during chewing or yawning? No ( ) Yes ( )
Does (or has) your child have (or had) frequent headaches or pain in or about the ears, eyes, or cheeks? No ( ) Yes ( )

DENTAL DISEASE PREVENTION

How often does your child brush? _____ times per _____ No ( ) Yes ( )
Does your child use dental floss? No ( ) Yes ( )
Does someone assist your child with brushing and cleaning the teeth? No ( ) Yes ( )
Does someone inspect for thoroughness after the procedure? No ( ) Yes ( )
Does your child use a fluoride toothpaste? No ( ) Yes ( )
Has your child ever had a fluoride treatment? No ( ) Yes ( )
Has your child ever taken fluoride supplement or vitamins with fluorides? No ( ) Yes ( )

Drinking water source:

City water supply _____ Name of city _____
Private well or other than city _____ Has a fluoride analysis been done? _____
Date of analysis _____ Fluoride content _____

_____ _____
►**SIGNATURE (Parent or guardian)** ►**DOCTOR SIGNATURE**

DENTIST'S COMMENTS: MEDICAL CONSULTATION RECOMMENDED? NO_____ YES _____ Date requested_____
PURPOSE FOR CONSULTATION: _____

SEMI-ANNUAL REVIEW OF MEDICAL-DENTAL HISTORY: If history remains essentially unchanged, sign below

Date _____ Parent _____ Doctor _____

Date _____ Parent _____ Doctor _____

Date _____ Parent _____ Doctor _____

A new history form should be completed at least every 2 years.