# Child or Young Adult - Medical and Dental History

Patient's primary care physician name and phone:
How would you describe your child's overall health?
When was the child's last physical?
Has your child ever been hospitalized for any reason? Y N
If so, why and when?
Is your child currently taking any medications? Y N
If so, please list each medication and the reason it is being taken:

Is your child allergic to, or had a reaction to, any of the following? Circle all that apply:

| | | | |
|---|---|---|---|
| Codeine | Latex | Nitrous Oxide | |
| Local anesthetic | Penicillin | Amoxicillin | Others: |
| Topical anesthetic | Aspirin | Zithromax | |

Does your child require antibiotic PRE-MEDICATION prior to their dental visit? Y N
If so, why?
If so, which antibiotic has been given in the past?

Please circle any physical or developmental issues your child may experience:

| | |
|---|---|
| Cerebral palsy | Seizures, fainting, or epilepsy |
| Heart problems | Blood or bleeding problems |
| Asthma | Hepatitis or jaundice |
| Allergies | Breathing problems |
| Muscular problems | Canker sores |
| Bone or joint problems | Cold sores |
| Hormone problems | Kidney problems |
| Leukemia | Cancer |
| Diabetes or blood sugar problems | Cleft lip or cleft palate |
| Skin conditions | Digestion problems |
| Hearing problems | Vision problems |
| Frequent sore throats | Frequent ear infections |
| Tonsillectomy | Developmental disability |
| Autism | Asperger's Syndrome |
| Developmental delay | Learning disability |
| ADD/ADHD/OCD | Hyperactive behavior |
| Eating disorder | Aggressive behavior |
| Shy behavior | Strong gag reflex |
| Swallowing disorder | Speech disorder |
| Trouble saying R, S or L sounds | |

If necessary, please explain any "yes" answers:

Does your child have any condiition or problem not listed which we should know about?

Is your child current on all childhood vaccinations? Y N
Has your child received the HPV (Gardisil) Vaccine? Y N

Please help us learn about your child's experiences with dentistry:
What is the reason for this visit?

What are your concerns about your child's teeth and oral health?

Has your child had any bad dental or medical experiences in the past? Y N
If yes, please explain:

Is this your child's first dental visit? Y N
If not, date of last visit: Name of former dentist:
Date of last x-ray: Treatment performed:

Is your child seeing an orthodontist or had braces in the past? Y N Date:
If so; name of orthodontist:

Is your child seeing a speech therapist or had speech therapy? Y N Date:
If so, name of speech therapist:

Has your child ever had any injuries to his or her teeth, mouth, head or jaws? Y N
If yes, please describe:

Does your child drink juice or soda most days? Y N
Does your child eat sweets, chips or gummies most days? Y N
Does your child drink milk most days? Y N

Does your child brush daily? Y N Brand of toothpaste:
Does an adult assist with brushing? Y N
Does your child use an electric toothbrush? Y N
Does your child floss? Y N
Does an adult assist with flossing? Y N

Does your child have any of the following mouth habits? Y N Circle all that apply:

| | | |
|---|---|---|
| Mouth breathing | Finger sucking | Open mouth at rest |
| Teeth grinding | Lip sucking | Drooling |
| Nail biting | Pacifier | Other: |
| Frequent Sippy cup | Tongue thrust | |

Does your child receive fluoride in any way? Y N Circle all that apply:

| | |
|---|---|
| Vitamins | Water supply |
| Tooth paste | Tablets or drops |
| Mouthwash | Brush-On Gel |
| School varnish | Other: |

Is there any other information you would like us to know about your child?