Patient Name: _____ Date of Birth: _____

Pediatric Health History Form

Patient's Name: _____ Date of Birth: _____

Name of Physician/Group: _____ Phone number: _____

Address: _____

(street) (city, state, zip)

☐Yes ☐No Is your child in general good health?

…… Date of last physical examination: _____ Height: _____ Weight:_____

☐Yes ☐No Is your child currently being treated by a physician? If yes, explain: _____

☐Yes ☐No Has your child ever been hospitalized? If yes, please give reason and dates: _____

_____

☐Yes ☐No Is your child currently taking any medication (prescription or over-the-counter), vitamins or dietary supplements?

If yes, please list: _____

_____

☐Yes ☐No Is your child allergic to anything? If yes, describe: _____

Please check if your child has had treatment or problems with any of the following:

☐ Heart disease	☐Bleeding/transfusions	☐ Asthma/breathing	☐ Blood dyscrasias
☐ Liver/GI disease	☐ Anemia	☐ Diabetes	☐ HIV/AIDS
☐ Kidney disease	☐ Rheumatic fever	☐ Hepatitis	☐ Mental delays
☐ Speech/hearing	☐ Seizures	☐ Cleft lip/palate	☐ Physical delays
☐ Eyesight	☐ Congenital birth defects	☐ Personality/social	☐ Endocrine/growth
☐ Cancer/tumors	☐ Recurrent headaches	☐ Frequent infections	☐ Autism
☐ Cerebral palsy	☐ Significant injuries	☐ Adverse Drug reactions	☐ Other problems
☐ Snoring	☐ Head/face trauma		

Please elaborate on any checked items: _____

_____

_____

_____

In terms of development, do you consider your child to be: ☐ Advanced
☐ Progressing normally
☐ Slower to reach milestones

Was your child: ☐ Breastfed ☐ Bottle fed What age was it stopped? _____

How often does your child receive the following?

_____ Sugar sweetened beverages (examples: fruit juice, soda, chocolate milk, sports drinks, etc)

_____ Gummies, dried fruits, gummy vitamins

_____ Granola bars, protein bars

_____ Dry cereal/chips/crackers

_____ Snacks (of any kind) between meals

☐Yes ☐No Does your child participate in any sports or similar activities?

☐Yes ☐No If yes: Does your child wear a mouthguard during these activities?

Patient Name: _____ Date of Birth: _____

Pediatric Dental History Form

Has your child ever been to the dentist? ☐No, this is the first dental visit
☐Yes. If yes, please complete the following:

Name of previous dentist or practice: _____

Address: _____ Phone number: _____

Date of last dental visit: _____ Reason for the last visit?: _____

Date of last dental x-rays (if taken): _____

At-Home Oral Hygiene

How often does your child brush their teeth? ☐Once a day in the morning/night (circle one) ☐ Twice a day ☐Other:_____

What kind of toothpaste/toothbrush? _____

How often does your child floss? ☐Once a day in the morning/night (circle one) ☐ 2-3 times a week ☐Other: _____

What kind of floss? _____

Does your child use mouthwash? ☐Once a day in the morning/night (circle one) ☐ Twice a day ☐Other:_____

If yes, what kind of mouthwash? _____

Does your child use any other dental home care products? ☐Yes ☐No

If yes, which kind? _____

Dental history

Is your child currently experiencing toothache or discomfort?..	☐Yes	☐No	If yes, explain: _____
Does/did your child ever suck on a finger, thumb or pacifier? ..	☐Yes	☐No	If yes, explain: _____
Do your child's gums bleed?.....	☐Yes	☐No	If yes, explain: _____
Are any teeth loose?	☐Yes	☐No	If yes, explain: _____
Any history of trauma to the mouth or teeth?.....	☐Yes	☐No	If yes, explain: _____
Does your child grind or clench teeth?.....	☐Yes	☐No	If yes, explain: _____
Has your child ever had clicking, popping or pain in the jaw?....	☐Yes	☐No	If yes, explain: _____
Has your child had any orthodontic treatment, such as braces?	☐Yes	☐No	If yes, when: _____
			If yes, do he/she wear a retainer? _____
Does your child have any sensitive teeth?.....	☐Yes	☐No	If yes, explain: _____
Does your child have any discolored teeth?.....	☐Yes	☐No	If yes, explain: _____

Any additional concerns you would like to address? _____

_____

Fluoride History

☐Yes ☐No Is your home water supply fluoridated?

☐Yes ☐No Do you use tap water for drinking?

☐Yes ☐No Does your child use toothpaste with fluoride?

☐Yes ☐No Do you give your child any other fluoride?

☐Yes ☐No If recommended, may your child have a topical fluoride treatment?

Authorization and Release

I certify that I have read and understand the above information. To the best of my knowledge, I have answered every completely and accurately. I will inform my dentist of any change in my health and/or medication. I understand the importance of a truthful medical and dental history and that my dentist and the staff will rely on this information for treating me. Further, I will not hold my dentist or any other member of the dental team, responsible for any errors or omissions that I may have made in the completion of these forms. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

Signature of Patient: _____ **Date**: _____
(Parent/guardian if minor)

Signature of Dentist: _____ **Date**: _____