Child's Play
Pediatric Dentistry

# Medical & Dental History

TODAY'S DATE: DD / MMM/ YYYY

| CHILD'S NAME FIRST / LAST | DATE OF BIRTH: DD / MM / YYYY |
|---|---|
| | |

NAME OF PARENT / GUARDIAN COMPLETING THIS FORM

## MEDICAL HISTORY

Is your child presently under the care of a physician for anything other than regular care? NO ☐ YES ☐

- If so, for what?

Are your child's immunizations current? NO ☐ YES ☐

Is your child allergic to anything? NO ☐ YES ☐

- If yes, what (eg. Latex, Penicillin, Seasonal)?

Is your child taking any medications or supplements? NO ☐ YES ☐

- If yes, what and what dose?

Has your child had General Anesthetic? NO ☐ YES ☐

- Please specify reason:

Has your child's doctor ever recommended antibiotics before dental treatment? NO ☐ YES ☐

| Does your child have or has your child ever had a history of: | | | |
|---|---|---|---|
| Heart Murmur? | NO ☐ YES ☐ | Thyroid Disease? | NO ☐ YES ☐ |
| Heart Disease or Rheumatic Fever? | NO ☐ YES ☐ | High/Low Blood Pressure? Circle One | NO ☐ YES ☐ |
| Seizures / Epilepsy? | NO ☐ YES ☐ | Fainting? | NO ☐ YES ☐ |
| Diabetes? | NO ☐ YES ☐ | Premature Birth? | NO ☐ YES ☐ |
| Liver Disease? | NO ☐ YES ☐ | Bleeding Problems? | NO ☐ YES ☐ |
| Kidney Disease? | NO ☐ YES ☐ | Sleep Apnea? | NO ☐ YES ☐ |
| Asthma? | NO ☐ YES ☐ | Development Delay? | NO ☐ YES ☐ |
| Severity: | | If so, please specify: | |
| Genetic Disorder? | NO ☐ YES ☐ | Cancer? | NO ☐ YES ☐ |
| Diagnosis: | | Diagnosis: | |
| Behavioral Issues? NO YES | | Eg. Autism, ADHD, Depression – Please specify: | |
| Comments / Additional Notes: | | | |

Has your child had a history of any conditions not included above? NO ☐ YES ☐

Please specify:

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## DENTAL HISTORY

| | |
|---|---|
| | |
| NAME OF CHILDREN'S PHYSICIAN? | OFFICE PHONE |
| | |
| NAME OF CHILDREN'S SPECIALIST? | OFFICE PHONE |
| | |
| NAME OF FAMILY DENTIST? | OFFICE PHONE |
| WHAT IS THE MAIN REASON FOR YOUR VISIT WITH US TODAY? | |
| HOW OFTEN DOES YOUR CHILD SEE THE DENTIST? | DATE OF LAST VISIT DD/MMM/YYYY |
| | |
| HAS YOUR CHILD EVER HAD ANY INJURIES TO THEIR HEAD, MOUTH OR TEETH? | NO ☐ ☐ YES, PLEASE EXPLAIN |
| | |

| | | | |
|---|---|---|---|
| DOES YOUR CHILD TAKE FLUORIDE VITAMINS? | NO ☐ YES ☐ | DOES YOUR CHILD USE FLUORIDE TOOTHPASTE? | NO ☐ YES ☐ |
| DOES YOUR CHILD HAVE ANY ORAL HABITS? | NO ☐ YES ☐ | PLEASE EXPLAIN: | |
| HAS YOUR CHILD HAD ANY NEGATIVE EXPERIENCES WITH DENTISTS OR DOCTORS? | NO ☐ YES ☐ | PLEASE EXPLAIN: | |
| HAS YOUR CHILD SEEN ANY OTHER DENTAL SPECIALIST? (ORTHODONTIST/ENDODONTIST) | NO ☐ YES ☐ | IF YES, WHO: | |

## PARENT / GUARDIAN ACKNOWLEDGEMENT

I hereby certify that I have read and understand the previous information and that it is accurate, true and complete to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health. If there is ever a change in my child's health, I will inform Child's Play Pediatric Dentistry at my child's next dental appointment without fail.

Please initial: _____

Signature: _____ Date: _____