Pediatric Medical History

A. Patrick Smithwick III, DDS
Board Certified Pediatric Dentist

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KIDS MILE HIGH
PEDIATRIC DENTISTRY
ORTHODONTICS

Childs Full Name: _____ Gender: (M) (F) Nickname: _____ Date of birth: __/__/____
Address: _____ City: _____ State: _____ Zip: _____ Home phone: _____
Cell: _____ Email: _____ Referred by : _____

Parent 1 Information Legal Custody Y ☐ N ☐
Name _____
Occupation _____
Employer _____ How long _____
Business Phone _____
Social Security _____
Birthdate _____

Parent 2 Information Legal Custody ☐ Y ☐ N
Name _____
Occupation _____
Employer _____ How long _____
Business Phone _____
Social Security _____
Birthdate _____

Parent 3 Information Legal Custody Y ☐ N ☐
Name _____
Occupation _____
Employer _____ How long _____
Business Phone _____
Social Security _____
Birthdate _____

Dental Insurance
Subscriber _____
Plan Name _____
Group # _____
Identification # _____

Medical History

Name/address/phone of primary physician: _____
Height:_____ Weight: _____ Date of last physical examination: _____
Name/address/phone of medical specialists: _____
Is your child being treated by a physician at this time? Reason ..... Y ☐ N ☐
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?..... Y ☐ N ☐
List name, dose, frequency & date started: _____
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?
List date & describe: _____
Has your child ever had a reaction to or problem with an anesthetic? Describe: ..... Y ☐ N ☐
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List ..... Y ☐ N ☐
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List ..... Y ☐ N ☐
Is your child up to date on immunizations against childhood diseases?..... Y ☐ N ☐

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of these conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions..... Y ☐ N ☐
Problems with physical growth or development ..... Y ☐ N ☐
Sinusitis, chronic adenoid/tonsil infections ..... Y ☐ N ☐
Sleep apnea/snoring, mouth breathing, or excessive gagging ..... Y ☐ N ☐
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease ..... Y ☐ N ☐
Irregular heart beat or high blood pressure ..... Y ☐ N ☐
Asthma, reactive airway disease, wheezing, or breathing problems ..... Y ☐ N ☐
Cystic Fibrosis ..... Y ☐ N ☐
Frequent colds or coughs, or pneumonia ..... Y ☐ N ☐
Frequent exposure to tobacco smoke ..... Y ☐ N ☐
Jaundice, hepatitis, or liver problems ..... Y ☐ N ☐
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ..... Y ☐ N ☐
Lactose intolerance, food allergies, nutritional deficiencies or dietary restrictions ..... Y ☐ N ☐
Prolonged diarrhea, unintentional weight loss, concerns with weight or eating disorder ..... Y ☐ N ☐
Bladder or kidney problems ..... Y ☐ N ☐

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Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems ..... Y ☐ N ☐
Rash/hives, eczema or skin problems ..... Y ☐ N ☐
Impaired vision, hearing, or speech ..... Y ☐ N ☐
Developmental disorders, learning problems/delays, or intellectual disability ..... Y ☐ N ☐
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures ..... Y ☐ N ☐
Autism/autism spectrum disorder ..... Y ☐ N ☐
Recurrent or frequent headaches/migraines, fainting, or dizziness ..... Y ☐ N ☐
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) ..... Y ☐ N ☐
Attention deficit/hyperactivity disorder (ADD/ADHD) - ..... Y ☐ N ☐
Behavioral, emotional, communication, or psychiatric problems/treatment ..... Y ☐ N ☐
Abuse (physical, psychological, emotional, or sexual) or neglect ..... Y ☐ N ☐
Diabetes, hyperglycemia, or hypoglycemia ..... Y ☐ N ☐
Precocious puberty or hormonal problems ..... Y ☐ N ☐
Thyroid or pituitary problems ..... Y ☐ N ☐
Anemia, sickle cell disease/trait, or blood disorder ..... Y ☐ N ☐
Hemophilia, bruising easily, or excessive bleeding ..... Y ☐ N ☐
Transfusions or receiving blood products ..... Y ☐ N ☐
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant ..... Y ☐ N ☐
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS ..... Y ☐ N ☐

Provide details here:

Is there any other significant medical history pertaining to this child or his/her family that the Dentist should be told?... Y ☐ N ☐
If yes, describe _____

What is your primary concern about your child's oral health? _____

How would you describe: *(please circle one)*

Your child's oral health?	Excellent	Good	Fair	Poor	
Your oral health?	Excellent	Good	Fair	Poor	
The oral health of your other children?	Excellent	Good	Fair	Poor	Not applicable

Is there a family history of cavities? Y ☐ N ☐ If yes, indicate all that apply: Mother Father Brother Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	Y ☐ N ☐ _____	Toothache	Y ☐ N ☐ _____
Mouth sores or fever blisters	Y ☐ N ☐ _____	Injury to teeth, mouth, or jaws	Y ☐ N ☐ _____
Bad breath	Y ☐ N ☐ _____	Clenching/grinding his/her teeth	Y ☐ N ☐ _____
Bleeding gums	Y ☐ N ☐ _____	Jaw joint problems (popping, etc.)	Y ☐ N ☐ _____
Cavities/decayed teeth	Y ☐ N ☐ _____	Excessive gagging	Y ☐ N ☐ _____

Sucking habit after one year of age Y ☐ N ☐ If YES, which: Finger Thumb Pacifier Other
For how long? _____

How often does your child brush his/her teeth?_____Times per day_____ Does someone help your child brush? Y ☐ N ☐

How often does your child floss his/her teeth? Never Occasionally Daily Does someone help your child floss? Y ☐ N ☐

What type of toothbrush does your child use? Hard Medium Soft Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? City/community supply Private well Bottled water
Do you use a water filter at home? If YES, name the filtering system?_____

Please circle all sources of fluoride your child receives:
Drinking water Toothpaste Over-the-counter rinse Prescription rinse/gel
Prescription drops/tablets/vitamins Fluoride treatment in the dental office
Fluoride varnish by pediatrician/other practitioner Do you use a water filter at home?

Does your child regularly eat 3 meals a day? Y ☐ N ☐
Is your child on a special or restricted diet? Y ☐ N ☐ If YES, describe: _____
Is your child a 'picky eater? Y ☐ N ☐ If YES, describe: _____
Does your child have a diet high in sugars or starches? Y ☐ N ☐ If YES, describe: _____
Do you have any concerns regarding your child's weight? Y ☐ N ☐

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How frequently does your child have the following? *(please circle one)*

Candy or other sweets	Rarely	1-2 times/day	3 or more times/day	Product _____
Chewing gum	Rarely	1-2 times/day	3 or more times/day	Type _____
Snacks between meals	Rarely	1-2 times/day	3 or more times/day	Usual snack _____
Soft drinks *	Rarely	1-2 times/day	3 or more times/day	Product _____

(*Such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks or energy drinks)

Does your child participate in any sports or similar activities? Y □ N □ If YES, list: _____

Does your child wear a mouth-guard during these activities? Y □ N □ If YES, type: _____

Has your child been examined or treated by another dentist? Y □ N □

If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? Y □ N □ Date of most recent dental x-rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? Y □ N □ If YES, when: _____

Has your child ever had a difficult dental appointment? Y □ N □ If YES, describe: _____

How do you expect your child will respond to dental treatment? Very well Fairly well Somewhat poorly Very poorly

Is there any other change in the child's medical, dental, or family history that the dentist should be told? Y □ N □

Describe: _____

_____	_____	_____	_____
Signature of parent/guardian	Relationship to child	Signature of staff member reviewing history	Date