Pediatric Dentistry, P.C. Name_____

MEDICAL HISTORY QUESTIONAIRE

Date_____

1. Does the patient have any health problems? Yes No

If yes,

explain_____

2. Is the patient currently seeing a physician for any problem? Yes No

If yes,

explain_____

3. Did the patient have any health problems or illnesses when younger or at birth? Yes No

If yes,

explain_____

4. Does the patient take any prescribed medications? Yes No

If yes, list (including dose)

5. Has the patient ever had any allergic or bad reactions to foods or medicines? Yes No

If yes,

describe_____

6. Has the patient ever been injured or stayed in hospital overnight? Yes No

If yes,

explain_____

7. Is the patient pregnant or has she been pregnant in the past? Yes No

Is the patient taking contraceptive pills or other contraceptive agents? Yes No

8. Has the patient ever had a blood transfusion? Yes No

9. Does the patient have or ever had any of the following?

·blood problems such as sickle cell anemia_____ Yes No

·easy bleeding or bruising_____ Yes No

·seizures or fainting _____ Yes No

·frequent headaches_____ Yes No

·heart murmur, heart defect or rheumatic fever_____ Yes No

·breathing problems or asthma_____ Yes No

·frequent cough or tuberculosis (T.B.)_____ Yes No

·hepatitis or liver problems_____ Yes No

·stomach or bowel problems_____ Yes No

·diabetes-(sugar), endocrine or hormone problems_____ Yes No

·kidney problems_____ Yes No

·hives or skin rash_____ Yes No

·AIDS or HIV infection_____ Yes No

·venereal disease_____ Yes No

·birth defect or disability_____ Yes No

10. Does the patient have any behavior or learning problems_____ Yes No

What grade at school is the patient

in?_____

11. Who takes care of the patient at

home?_____

12. Has your child ever had surgery?_____ Yes

No

13. Is there any history of problems with general anesthesia in the family?_____ Yes No
14. Has the patient had any disease, condition or problem not listed above? Yes No
If yes,
explain_____
15. Name of patient's pediatrician or family
physician_____
Address_____Phone_____
____
Date of last physical
examination_____

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DENTAL HISTORY QUESTIONAIRE

1. Is this your child's first visit to the dentist_____ Yes No
If not, when was their last
visit?_____
2. What are your main concerns or reasons for this
visit?_____
3. Were any x-rays or radiographs taken at a prior visit to a dentist?_____ Yes No
4. In considering your child's diet, would you describe it as a low, medium or high sugar diet?
5. Does your child eat sweets on a daily basis? _____ Yes No
6. Does your child drink soda pop or juice on a regular basis? _____ Yes No
7. If yes, how many glasses a day are regularly consumed
_____
8. When does your child brush their
teeth?_____
and do you help them? _____
9. How does your child receive fluoride? (Circle all that apply)
Community water – Well water – Fluoride drops/tablets - Fluoride rinse/gel
10. Have any cavities been noticed in the past? _____ Yes No
11. Have there been injuries to any teeth such as blows, falls, chips. etc. _____ Yes No
If so, please describe:_____
12. Has your child had any problem with dental treatment in the past? _____ Yes No
If so, please explain:
_____

I authorize the dentist to perform diagnostic procedures and treatment as
deemed necessary for proper dental care.
I authorize the release of any information concerning my child's healthcare,
advice and treatment for the purpose of evaluating and administering claims
for insurance benefits.

I acknowledge that I have received a copy of this office's "Notice of Privacy Practices".
I acknowledge that I have received a copy of "The Financial Policy for this
Office."
TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION
IS COMPLETE AND ACCURATE.

_____ _____
Signature of Parent/Legal Guardian Date