Tots N' Teens Pediatric Dental Specialist

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Child Health History

Please fill out one form for each child.

Child's name | Date of birth | Date

DENTAL HEALTH

Why did you bring your child to the dentist today?

Time since child's last dental exam | Last tooth cleaning

☐ First visit ever

For most drinking & cooking do you use: ☐ Town water ☐ Well water ☐ Bottled water

If well or bottled, has the water been tested for fluoride? ☐ Yes ☐ No

Results

Does your child take fluoride supplements? ☐ Yes ☐ No

Dose and frequency

Have there been any injuries to the face, mouth or teeth? ☐ Yes ☐ No

Please give dates and descriptions

Has your child ever sucked a thumb or fingers, or used a pacifier? ☐ Yes ☐ No

Any other habits? | Until what age?

Did your child go to sleep with a bottle, with a sippy cup, or while nursing? ☐ Yes ☐ No

Until what age?

Does your child have any of these? (check all that apply)

- ☐ Snoring
- ☐ Tooth grinding
- ☐ Frequent middle ear infections
- ☐ Restless sleep
- ☐ Daytime mouth breathing
- ☐ Bedwetting now
- ☐ Environmental allergies
- ☐ Speech problems
- ☐ Nighttime mouth breathing
- ☐ Hearing deficiency
- ☐ History of sleep apnea
- ☐ Jaw clicking when eating

Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had an orthodontic examination or orthodontic treatment? ☐ Yes ☐ No

What is the tooth decay rate of your child's siblings? ☐ None ☐ Slight ☐ Moderate ☐ Severe

Is your child nervous or frightened during dental visits? If yes, please mark:

Least nervous ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Most nervous

Has your child had any unfavorable medical or dental experience? ☐ Yes ☐ No

If so, please explain

MEDICAL HEALTH

Name of pediatrician or family physician | Phone | Date of last physical

Is your child now under the care of a physician? ☐ Yes ☐ No

If so, what is the condition being treated?

Has your child had any serious illness, injury, or trouble at birth? ☐ Yes ☐ No

If so, please describe and give dates

Has your child ever been hospitalized or had surgery (including tonsils/adenoids)? ☐ Yes ☐ No

Date and reason

Has your child ever had any of the following? (check all that apply)

- ☐ Heart murmur or heart disease
- ☐ Asthma or breathing problems
- ☐ Diabetes
- ☐ Hepatitis, jaundice or liver problems
- ☐ Growth problems
- ☐ HIV (AIDS)
- ☐ Learning or behavior problems
- ☐ Limits on physical activities
- ☐ Congenital heart condition
- ☐ Anemia or sickle cell
- ☐ Thyroid problem
- ☐ Fainting spells or seizures
- ☐ Hives or skin rash
- ☐ Blood transfusion
- ☐ Mental/emotional problems
- ☐ Other
- ☐ Antibiotics advised before dental care
- ☐ Abnormal bleeding or bruising
- ☐ Kidney problems
- ☐ Bone disorders or arthritis
- ☐ Tuberculosis
- ☐ Birth defect
- ☐ Physical disability

Please describe anything checked above

Does your child take any medicines, vitamins or supplements? ☐ Yes ☐ No

If so, what / how often?

Is your child allergic to any medicine (antibiotics, pain relievers, local anesthetics), latex or foods? ☐ Yes ☐ No

Please list and describe the reaction

Any disease, condition or problem not listed above that we should know about?

Name of parent/guardian | Signature of parent/guardian | Relationship | Date