Smile Wright
DENTAL

Pediatric Medical History

Child's legal name: _____ Nickname: _____

Date of birth: _____ Age: _____ Race/Ethnicity: _____

Birth sex: M F Current gender identity: _____ Pronouns: _____

SS# _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Guardian's name: _____ Guardian's date of birth: _____

SS# _____

Primary phone: _____ Secondary phone: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Name/age and relationship of others living in the household: _____

Nearest Relative or Family Friend Not Living with Patient _____

Who may we thank for referring you? _____

Primary physician: _____ Last visit: _____

Address/phone: _____

Medical specialists: _____ Last visit: _____

Address/phone: _____

Is your child being treated by a physician at this time? Y☐N☐
Reason _____
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? Y☐N☐
List date & describe: _____
Has your child ever had a reaction to or problem with an anesthetic? Y☐N☐
Describe _____
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? Y☐N☐
List _____
Is your child allergic to latex or anything else such as metals, acrylic, or dye? Y☐N☐
List _____
Is your child up to date on immunizations against childhood diseases? Y☐N☐
Is your child immunized against human papilloma virus (HPV)? 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 those 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☐
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis	Y☐N☐
Rash/hives, eczema, or skin problems	Y☐N☐
Impaired vision, visual processing, 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, or 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? If YES, describe. Y☐N☐

_____

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

How would you describe:

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☐	_____
Mouth sores or fever blisters	Y☐N☐	_____
Bad breath	Y☐N☐	_____
Bleeding gums	Y☐N☐	_____
Cavities/decayed teeth	Y☐N☐	_____
Toothache	Y☐N☐	_____
Injury to teeth, mouth, or jaws	Y☐N☐	_____
Clinching/grinding his/her teeth	Y☐N☐	_____
Jaw joint problems (popping, etc.)	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 _____ 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? Y☐N☐ If yes, type of filtering system: _____

Please check 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 ☐ Other:_____

Does your child regularly eat 3 meals each 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☐ If YES, describe:_____

How frequently does your child have the following?

Snacks between meals	☐Rarely	☐1-2 times/day	☐3 or more times/day	Product_____
Candy or other sweets	☐Rarely	☐1-2 times/day	☐3 or more times/day	Type_____
Chewing gum	☐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_____

Please note other significant dietary habits:_____

(*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 mouthguard 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 anything else we should know before treating your child? Y☐N☐ If YES, describe:_____

_____

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

Smile Wright DENTAL

Medical/Dental History Update

Is your child being treated by a physician at this time? Y☐N☐
Reason _____
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 had any illness, surgery, injury, allergic reaction, or medical emergency in the past year? Y☐N☐
Describe: _____
Has your child ever had a reaction to or problem with an anesthetic? Y☐N☐
Describe: _____
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? Y☐N☐
List: _____
Is your child allergic to latex or anything else such as metals, acrylic, or dye? Y☐N☐
List: _____
Have there recently been any significant changes/disruptions to your child's family, home, or school routines? Y☐N☐
Describe: _____
What is your primary concern regarding your child's oral health?
Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? Y☐N☐
Describe: _____
Has your child's diet changed significantly since his/her last dental visit? Y☐N☐
Describe: _____
Has your child been treated by another dentist/dental professional since last visiting our office? Y☐N☐
Reason: _____
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	Date	Signature of staff member reviewing history

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