NEW PATIENT MEDICAL HISTORY FORM

Child's Legal Name: _____

Date of Birth: _____

Birth Sex: M F **Current Gender Identity:** M F **Preferred Pronouns:** _____

Race/Ethnicity:

Name/Age of Relationship of Others Living in the Household:

_____

_____

_____

_____

_____

Primary Physician: _____

Address/Phone: _____

Medical Specialists (if applicable): _____

Address/Phone: _____

Is your child being treated by a physician at this time? **Yes/No**

Reason: _____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? **Yes/No**

List name, dose, frequency, & date started: _____

_____

Has your child every been hospitalized, had surgery or a significant injury, or been treated in an emergency department?

Yes/No

List, date, & describe: _____

_____

Has your child ever had a reaction to or problem with an anesthetic? **Yes/No**

Please describe: _____

_____

Is your child allergic to latex or anything else such as metal, acrylic, or dye? **Yes/No**

List: _____

_____

Has your child had a reaction or allergy to an antibiotic, sedative, or other medication? **Yes/No**

List: _____

_____

Is your child up to date on immunizations against childhood diseases? **Yes/No**

Is your child immunized against human papilloma virus (HPV) **Yes/No**

Please circle 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. Circle NO after each line if no conditions apply to your child.

Complication before or during birth, prematurity, birth defects, syndromes, or inherited conditions **Yes/No**

Problems with physical growth development **Yes/No**

Sinusitis, chronic adenoid/tonsil infections **Yes/No**

Sleep apnea/snoring, mouth breathing or excessive gagging **Yes/No**

Congenital heart defects/disease, heart murmur, rheumatic fever, rheumatic heart disease **Yes/No**

Irregular heartbeat or high blood pressure **Yes/No**

Asthma, reactive airway disease, wheezing, or breathing problems **Yes/No**

Cystic Fibrosis **Yes/No**

Frequent colds coughs, or pneumonia **Yes/No**

Frequent exposure to tobacco smoke **Yes/No**

Jaundice, hepatitis, or liver problems **Yes/No**

Gastroesophageal /acid reflux disease (GERD), stomach ulcers, or intestinal problems **Yes/No**

Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions **Yes/No**

Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder **Yes/No**

Bladder or kidney problems **Yes/No**

Fine /gross motor deficits, arthritis, limited use of arms or legs, muscle/bone joint problems /scoliosis **Yes/No**

Rash/hives, eczema, or skin problems **Yes/No**

Impaired vison, visual processing, hearing, or speech **Yes/No**

Development disorders, learning problems /delays, or intellectual disabilities **Yes/No**

Cerebral palsy, brain injury, epilepsy, or convulsions /seizures **Yes/No**

Autism/autism spectrum disorder **Yes/No**

Recurrent or frequent headaches/migraines, fainting, or dizziness **Yes/No**

Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) **Yes/No**

Attention deficit/hyperactivity disorder (ADD/ADHD) **Yes/No**

Behavioral, emotional, communication, or psychiatric problems/treatment **Yes/No**

Abuse (physical, psychological, emotional, or sexual) or neglect **Yes/No**

Diabetes, hyperglycemia, or hypoglycemia **Yes/No**

Precocious puberty or hormonal problems **Yes/No**

Thyroid, or pituitary problems **Yes/No**

Anemia, sickle cell disease/trait, or blood disorder **Yes/No**

Hemophilia, bruising easily, or excessive bleeding **Yes/No**

Transfusions or receiving blood products **Yes/No**

Cancer, Tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant **Yes/No**

Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS **Yes/No**

PLEASE PROVIDE DETAILS HERE:

_____

_____

_____

_____

_____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? **Yes/No**

If YES, please 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**

Is there a family history of cavities? **Yes/No**

If YES, circle all that apply **Mother Father Brother Sister**

Does your child have a history of any of the following?

Inherited dental characteristics **Yes/No**

Mouth sores or fever blisters **Yes/No**

Bad breath **Yes/No**

Bleeding gums **Yes/No**

Cavities/decayed teeth **Yes/No**

Toothache **Yes/No**

Injury to teeth, mouth, or jaws **Yes/No**

Clinching/grinding teeth **Yes/No**

Jaw joint problems (popping, etc.) **Yes/No**

Excessive gagging **Yes/No**

Sucking habit after one year of age **Yes/No**

For each YES, please describe in detail here:

_____

_____

_____

_____

_____

How often does your child brush their teeth? _____

Does someone help your child brush? **Yes/No**

How often does your child floss? **Never/Occasionally/Daily**

Does someone help your child floss? **Yes/No**

What type of toothpaste does your child use? **Fluoridated/Non-fluoridated**

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

What is the source of your drinking water at home? **City/Private Well/Bottled Water**

Do you use a water filter at home? **Yes/No**

Please circle all sources of fluoride your child receives:

Drinking water Toothpaste Over-the-counter rinse Prescription rinse/gel

Prescription drops/tablets/vitamins Fluoride varnish by pediatrician/other practitioner Dental provider

Is your child on a special or restricted diet? **Yes/No**

If YES, please describe: _____

Does your child have a diet high in sugars or starches? **Yes/No**

If YES, please describe: _____

How frequently does your child have the following?

Snacks between meal **Rarely/1-2X a day/3X a day or more**

Candy or other sweets **Rarely/1-2X a day/3X a day or more**

Chewing gum **Rarely/1-2X a day/3X a day or more**

Soft drinks* **Rarely/1-2X a day/3X a day or more**

(*such as juice, fruit-flavored drinks, soda, ola, carbonated beverages, sprots drinks, or energy drinks)

Does your child participate in any sports or similar activities? **Yes/No**

If YES, list: _____

Does your child wear a mouthguard during these activities? **Yes/No**

If YES, type: _____

Has your child been examined by another dentist? **Yes/No**

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

Were x-rays taken of the teeth or jaws? **Yes/No**

*Date of most recent dental x-*rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? **Yes/No**

Has your child ever had a difficult dental appointment? **Yes/No**

How do you expect your child will respond to dental treatment*?* **Good/Fair/ Somewhat poor/Very poor**

Is there anything else we should know before treating your child? **Yes/No**

If YES, describe: _____

_____

_____

signature of parent/guardian Relationship to child Date

signature of dentist signature of staff member reviewing history Date