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Howell
PEDIATRIC DENTISTRY

MEDICAL AND DENTAL HISTORY FORM

Thank you for providing your child's medical information. Thorough knowledge of your child's history will help us to provide optimal care. All information is confidential.

PATIENT INFORMATION

Last Name …… First Name ……Middle……

Nickname:…… Date of Birth (MM/DD/YYYY) ……

Address: ……

City: …… State: …… Zip Code……

E-mail: ……

Phone (Home)…… Work: ……Cellular:……

Name of Pediatrician……Telephone:……

Date of Last Visit:……

If your child has been seen or is currently being treated by a specialist, please circle:
Neurologist Cardiologist Endocrinologist Other:

Specialist Name……Telephone:……

Reason for today's visit:

How did you hear about our office?

Please tell us about your child's interests (pets/ favorite shows):

Allergy Information and Special Precautions

Does your child need to be pre-medicated (take antibiotics) before dental treatment? Yes No

Please circle if your child is allergic to any of the following:
Latex Sulfa Penicillin Amoxicillin Nuts Milk Protein

Tylenol (Acetaminophen) Motrin (Ibuprofen) Dyes Kiwi

Please list any other food or drug allergies:

List any medications, herbal or natural remedies that your child is currently taking:

Are your child's immunizations up-to-date? Yes No

Medical History

Please circle **Y** (yes) or **N** (no) to all of the following. Has your child ever had a history of:

Heart Murmur	Y	N	HIV/AIDS	Y	N
Heart Disease	Y	N	Autism Spectral Disorder	Y	N
Diabetes	Y	N	ADD/ADHD	Y	N
Tuberculosis	Y	N	Anemia	Y	N
Bleeding Disorders	Y	N	Thyroid Problems	Y	N
Kidney Disease	Y	N	Hepatitis	Y	N
Liver Disease	Y	N	Autoimmune Disease	Y	N

Ear/Hearing Problems	Y N	Cerebral Palsy	Y N
Visual/ Eye problems	Y N	Cystic Fibrosis	Y N
Asthma	Y N	Bone or Joint Disease	Y N
Psychiatric Condition	Y N	Neurological Disorder	Y N
Rheumatic Fever	Y N	Tumors	Y N
Radiation/Chemotherapy	Y N	Cancer	Y N
Seizures	Y N	Developmental Delay	Y N
Stomach/Intestinal Disorder	Y N	Speech Delay	Y N
High/ Low Blood Pressure	Y N	Hives/Skin Disorder	Y N
Fainting/Dizzy Spells	Y N	Muscular/Skeletal disorder	Y N
Seasonal Allergies	Y N	Genetic Disorder	Y N

Please list and describe any other medical conditions or surgeries that your child has had:

For our young adult female patients:
Are you currently taking birth control? Y N Not Applicable
Is there any possibility that you could be pregnant? Y N Not Applicable

Dental History

Date of last dental visit: When were last x-rays taken?

Name/telephone of previous dentist:

Please briefly describe your child's behavior at the dentist:

Does your child currently use a bottle or sippy cup?

Is your child being breast-feed?

Circle any of the following that applies to your child:

Thumb/Finger/Tongue Sucking Nail/Cheek/ Lip Biting Grinds Teeth
Mouth Breather Pacifier Use Other Habits:

Is your child currently taking fluoride drops or tablets?

How often does your child brush/floss?

Does your child use toothpaste with fluoride?

Has your child had any injuries to the teeth?

Does your child wear a mouth guard when playing contact sports?

Circle any of the below treatments that your child has had:
X-rays Happy gas (nitrous oxide) Sedation "Novocaine" Cleaning

Is there a family history of any of the following? Please circle:

Missing Teeth Extra Teeth Cavities/Decay Other:

Describe any other dental conditions that your child has:

Signature of Parent: **Date:**

Relation to Child: **Signature of Dentist:**

Acknowledgement of Receipt of Copy of Notice of Privacy Practice *__You May Refuse to Sign__*
Print Name Signature Date