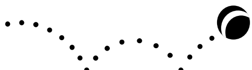

DUKE CHILDREN'S Pediatric Dentistry

PEDIATRIC MEDICAL/DENTAL HISTORY

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

RECORD #: ______________________________

MEDICAL HISTORY

DATE: ________________

Child's Physician ______________________________ Date of last exam ________ Date of last immunization __________

Address of your child's physician ______________________________ Office phone ____________________

1. Is your child in good health? .... ❑ Yes ❑ No ❑ Don't Know
2. Does your child have a health problem? .... ❑ Yes ❑ No ❑ Don't Know

   If yes, explain: ______________________________

3. Has your child ever been hospitalized, had general anesthesia or emergency room visits? ❑ Yes ❑ No ❑ Don't Know

   If yes, explain: ______________________________

Has your child ever had or been treated by a physician for:

	CHECK		
	YES	NO	?
PROBLEMS AT BIRTH			
HEART MURMUR			
HEART DISEASE			
RHEUMATIC FEVER			
ANEMIA			
SICKLE CELL ANEMIA			
BLEEDING/HEMOPHILIA			
BLOOD TRANSFUSION			
HEPATITIS			
AIDS OR HIV +			
TUBERCULOSIS			
LIVER PROBLEMS			
KIDNEY DISEASE			
DIABETES			

	CHECK		
	YES	NO	?
ARTHRITIS			
CANCER			
CEREBRAL PALSY			
SEIZURES			
AUTISM			
ASTHMA			
CLEFT LIP/PALATE			
SPEECH PROBLEMS			
HEARING PROBLEMS			
EYE PROBLEMS			
SKIN PROBLEMS			
TONSIL/ADENOID PROBLEMS			
SLEEP PROBLEMS			
EMOTIONAL/BEHAVIORAL PROBLEMS			

If yes to any of the above questions, please explain: ______________________________

____

Other problems: ______________________________

Allergies (please list): ______________________________

Past medications taken by child: ______________________________

Daily medications child is now taking: ______________________________

Grade child is in ____________________

School child attends ____________________

CHECK			
YES	NO	?	
			Has your child recently started to grow quickly?
			Do you think your child has stopped growing?
			Has your child shown any signs of reaching puberty? (Example: Girls - monthly period; Boys - shaving or voice change)

Do you consider your child to be: (check one)

Advanced in learning? ❑

Progressing normally? ❑

Slow learner? ❑

DENTAL HISTORY

What is your main concern about your child's dental health? ______________________________

____

Has your child been to a dentist before? ❑ Yes ❑ No If yes, date of last visit:__________ Date of last X-rays: ________

Former dentist's name: ______________________ Reason for leaving former dentist: ______________________

____

CHECK

YES	NO	?	
			Has your child experienced an unusual reaction to dental medication or anesthetic? If yes, explain below.
			Has your child experienced prolonged bleeding following dental treatment? If so, explain.
			Will your child be uncooperative? If yes, explain?
			Has your child experienced any complications following dental treatment? If yes, explain.
			Has your child inherited any family facial or dental characteristics? If yes, explain.
			Has your child had any injury to the teeth, jaws, or face? If yes, explain.
			Has your child had any clicking or pain in the jaw joints? If yes, explain.
			Was your child breast fed? When stopped? ______________________
			Was your child bottle fed? When stopped? ______________________
			Did your child use a pacifier? When stopped? ______________________
			Did your child suck a finger or thumb? When stopped? ______________________
			Does your child brush his/her own teeth?
			Does your child use dental floss?
			Do you usually help your child brush?
			Do your child's gums bleed when brushed?
			Did you or your child ever get instructions in brushing?
			Does your child use fluoride products: rinses, drops, or tabs?

Please check if your child has had problems with any of the following:

❑ Cavities ❑ Color of teeth ❑ Teeth sensitive to hot or cold ❑ Bleeding gums

❑ Tooth aches ❑ Gum infection ❑ Teeth sensitive to sweets ❑ Appearance of teeth

❑ Teeth bumped ❑ Grinds teeth ❑ Other dental problems

Explanations and comments: ______________________________

____

____

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report changes in my child's medical or dental status to the dentist, and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.

*PERSON COMPLETING THIS FORM: Signature:*______________________ *Date* ________

Relationship to patient: ______________________

*Medical and Dental History reviewed by:*______________________ *Date* ________