



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:

- | | | | |
|---------------------------------------|-----------------------------------------|---------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Color of teeth | <input type="checkbox"/> Teeth sensitive to hot or cold | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Tooth aches | <input type="checkbox"/> Gum infection | <input type="checkbox"/> Teeth sensitive to sweets | <input type="checkbox"/> Appearance of teeth |
| <input type="checkbox"/> Teeth bumped | <input type="checkbox"/> Grinds teeth | <input type="checkbox"/> 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 _____