CROSSROADS PEDIATRIC DENTISTRY

PEDIATRIC DENTAL AND MEDICAL HISTORY

Margaret E. Barry, D.D.S.

Child's Name and (Nickname)____________________Today's Date ____________

Date of Birth____________Age________Sex Male ☐ Female ☐ Is Child Adopted? Yes ☐ No ☐ From? ______

Mother's Name____________________Father's Name ____________________

Best Phone Number(s) to Reach You____________________

Name of Dental Insurance Policy Holder ____________________

Parents are: Married ☐ Divorced ☐ Single ☐ Other ☐ Describe,____________________

Does your child have ANY condition that requires ANTIBIOTICS prior to dental treatment? Yes ☐ No ☐

Please Answer Every Question Completely. Your Answers May Affect Your Child's Dental Care.

DENTAL HISTORY

DATE of Child's Last Visit to a Dentist ?____________________What Service?____________________

Has your Child complained of dental problems? Yes ☐ No ☐ What?____________________

Do you believe your Child has tooth decay? Yes ☐ No ☐ Don't Know ☐

Has your Child had any injury to head or teeth? Yes ☐ No ☐ Describe? ____________________

Has your Child lost any teeth due to injury? Yes ☐ No ☐ Describe?____________________

Does your Child have any mouth habits such as:

Thumb Sucking Yes ☐ No ☐ Nursing Bottle Habits Yes ☐ No ☐

Nail Biting Yes ☐ No ☐ Pacifier Yes ☐ No ☐

Mouth Breathing Yes ☐ No ☐ Speech Habits Yes ☐ No ☐ Describe ____________________

Has your Child had any orthodontic treatment, braces, appliances? Yes ☐ No ☐ Describe____________________

We Appreciate Your Taking the Time and Making the Effort to Answer These Questions.

ORAL HYGIENE

Does your Child brush teeth daily? Yes ☐ No ☐ Do YOU assist child with tooth brushing daily? Yes ☐ No ☐ Sometimes ☐

Is dental floss used? Yes ☐ No ☐ By Whom? Child ☐ Parent ☐ Both ☐ Daily ☐ Sometimes ☐

Is your water fluoridated Yes ☐ No ☐, or do you HAVE or NEED a Fluoride RX? HAVE ☐ NEED ☐

We Believe in Making Each Visit as Pleasant as Possible for You and for Your Child.

NATURE OF TODAY'S VISIT

New Patient Comprehensive Examination? Yes ☐ No ☐ or Emergency? Yes ☐ No ☐ Describe?____________________

What is your Child's attitude toward visiting the dentist? Positive ☐ Neutral ☐ Negative ☐

Has your Child had any unhappy dental experiences? Yes ☐ No ☐ Where, When? ____________________

Describe any concerns you have about your Child's behavior at the dentist?____________________

Your Answers to These Questions are Very Important to Your Child's Dental Care

MEDICAL HISTORY

Child's Primary Care Physician ____________________

Address____________________Phone ____________

Date of last physical examination____________________Results ____________________

Any other Physicians? ____________________

Other Physician's address and phone ____________________

Are your Child's immunizations up to date? Yes ☐ No ☐

Allergies/Sensitivities/Reactions:

Anesthetics, Local and/or General Yes ☐ No ☐ Describe?____________________

Sedative Agents Yes ☐ No ☐ Describe?____________________

Drugs or Medications (such as antibiotics) Yes ☐ No ☐ ____________________

Environmental such as pollen, dogs, cats, dust Yes ☐ No ☐ ____________________

Latex, Food, Dyes, Metal, Acrylic Yes ☐ No ☐ ____________________

Medications, including over-the-counter analgesics, vitamins and herbal supplements

What is the Child taking?____________________Dose?____________Frequency____________

Any reactions? Yes ☐ No ☐ ____________________

Hospitalizations and/or Surgeries

Reason (s), Date(s), Outcome(s) ____________________

Significant Injuries (such as to head or teeth, broken bones, severe lacerations, car accidents) Describe, date, outcome ____________________

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Has Child had ANY History with ANY of the following?

Complications during Pregnancy Yes □ No □
Prematurity Yes □ No □
Congenital Anomalies Yes □ No □
Cleft Lip/Palate Yes □ No □
Inherited Disorders Yes □ No □
Nutritional Deficiencies Yes □ No □
Problems of Growth or Stature Yes □ No □
Lesions (sores) in or around the mouth Yes □ No □
Chronic Adenoid/ Tonsil Infections Yes □ No □
Chronic Ear Infections Yes □ No □
Ear or Hearing Problems Yes □ No □
Eye or Visual Problems Yes □ No □
Sinusitis Yes □ No □
Speech Impairments Yes □ No □
Apnea/Snoring/Mouth-Breathing Yes □ No □
Transfusion Yes □ No □
Excessive Bleeding Yes □ No □
Bruising Easily Yes □ No □
Hemophilia Yes □ No □
Type? ______________________
Sickle Cell Disease Trait Yes □ No □
Cancer, Tumor, other Malignancy Yes □ No □
What? ______________________
Immune Disorder Yes □ No □
Chemotherapy Yes □ No □
What? ______________________
Radiation Therapy Yes □ No □
Hematopoietic cell (bone marrow)
Transplant: Yes □ No □
Diabetes Yes □ No □
Growth Delays Yes □ No □
Hormonal Problems Yes □ No □
Precocious Puberty Yes □ No □
Thyroid Problems Yes □ No □
Eating Disorder, Ulcer, Excessive
Gagging: Yes □ No □
GERD [Gastro Esophageal/
Acid Reflux Disease]: Yes □ No □
Hepatitis A B C or Variant Yes □ No □
Liver Disease Yes □ No □
Intestinal Problems Yes □ No □
Prolonged Diarrhea Yes □ No □
Unintentional Weight Loss Yes □ No □
Lactose Intolerance Yes □ No □
Dietary Restrictions Yes □ No □
What? ______________________
Kidney Disease or Infections Yes □ No □
Bladder Disease or Infections Yes □ No □
Sexually Transmitted Disease(s) Yes □ No □
Females: Pregnancy Yes □ No □
Birth Control Pills Yes □ No □

Asthma Yes □ No □
Asthma Medications, Triggers, Last Attack Hospitalizations:
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Tuberculosis Yes □ No □
Cystic Fibrosis Yes □ No □
Frequent colds, coughs, syncytial virus Yes □ No □
Reactive airway disease/breathing problems:
Yes □ No □
Smoking Yes □ No □
Congenital Heart Defect or Disease Yes □ No □
Heart Murmur Yes □ No □
Rheumatic Fever or Rheumatic
Heart Disease: Yes □ No □
Anemia Yes □ No □
Blood Disorder Yes □ No □
Arthritis Yes □ No □
Scoliosis Yes □ No □
Bone or Joint Problems Yes □ No □
TMJ (temporomandibular joint) Problems (clicking,
popping, locking, difficulties opening) Yes □ No □
Fever Blisters Yes □ No □
Eczema Yes □ No □
Rash/Hives Yes □ No □
Skin Condition Yes □ No □
Fainting Yes □ No □
Dizziness Yes □ No □
Autism Yes □ No □
Type? ______________________
Developmental Disorders Yes □ No □
What? ______________________
Learning Problems/Delays Yes □ No □
What? ______________________
Mental Disability Yes □ No □
Brain Injury Yes □ No □
Cerebral Palsy Yes □ No □
Convulsions/Seizures Yes □ No □
Epilepsy Yes □ No □
Type? ______________________
Headaches/Migraines Yes □ No □
Mild, Moderate, Major Duration? ______________________
Hydrocephaly Yes □ No □
Shunts Yes □ No □
Type? ______________________
Measles, Mumps Rubella, Scarlet Fever,
Varicella (Chicken Pox), Mononucleosis Yes □ No □
Cytomegalovirus (CMV), Pertusis
(Whopping cough) Yes □ No □
Human Immunodeficiency Virus/Acquired
Immune Deficiency Syndrome (HIV/AIDS) Yes □ No □
Is there a family history of Genetic Disorders,
problems with general anesthesia, or serious
medical problems or illnesses Yes □ No □
Passive Smoke Exposure Yes □ No □

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

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May we request release of your Child's medical records? Yes □ No □

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered completely and fully to my knowledge and satisfaction. I acknowledge that any errors or omissions that I have made in the completion of this form my affect my child's dental care, and I will do my best to correct these errors as soon as I become aware of them.

This information was discussed with and given by Mother □ , Father □ , Legal Guardian □, Other □ ______________________

Signature______________________________________Date______________________

Thank you for completing this form.
Margaret E. Barry, D.D.S.
Diplomate of the American Board of Pediatric Dentistry