cardinal
PEDIATRIC DENTISTRY

Medical/Dental History

Medical and dental history questions provide us with important information to evaluate, diagnose, and treat your child. Please answer all questions as accurately as possible. If there are any questions you do not understand, we are happy to assist you.

Child's Name_____ Date of Birth____/____/_____
First Last

MEDICAL HISTORY

Physician Name_____ Date of Last Medical Exam_____

Is your child up to date with his/her immunizations? Yes No

Is your child presently under medical care? Yes No Reason _____
(Other than routine visits)

List any medication(s) that the patient is currently taking:
_____

Does your child have allergies or reactions to medications, foods, drugs, anything? Yes No
If yes, ALLERGIC to_____

Has your child ever been hospitalized? Yes No
Reason/Date_____

Was your child born prematurely? Yes No
How many weeks gestation? _____

Has your child ever had a surgery under general anesthesia? Yes No
Reason/Date_____

Has your child now or ever had any of the following medical conditions?

- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Bleeding Disorder
- ❑ Hemophilia
- ❑ Anemia
- ❑ Sickle Cell
- ❑ Asthma/Reactive Airway Disease
- ❑ Tuberculosis
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Gastrointestinal (stomach) Problems
- ❑ HIV/AIDS
- ❑ Hepatitis
- ❑ Cancer/Tumors
- ❑ Congenital Birth Defects
- ❑ Rheumatic Fever
- ❑ Epilepsy/Seizures
- ❑ Autism/ASD
- ❑ Mental Disorders
- ❑ ADD/ADHD
- ❑ Developmental Delay
- ❑ Sinus Problems
- ❑ Hearing Impairment
- ❑ Vision Impairment
- ❑ Artificial Bones/Joints
- ❑ Allergy to Latex

If you answered yes to any of the above, please explain below:
_____
_____

Please list any other medical conditions
_____

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Child's Name _____

DENTAL HISTORY

What is the reason for your visit today? _____
Is this your child's first visit to the dentist? Yes No If no, date of last visit_____
Why did you choose to change dentists? _____
If applicable, were any x-rays taken at previous dental visits? Yes No
Does your child have any dental pain? Yes No
Has your child experienced any major injuries to their mouth, face, or teeth? Yes No
Characterize your child's dental experiences in the past: ___Positive ___Neutral ___Negative
How often does your child brush? _____
How often does your child floss? _____
Does your child use fluoride toothpaste? _____
Does your child take fluoride supplements? _____

Is there anything else you would like us to know about your child's dental/oral health?

_____
_____

SOCIAL INFORMATION

Please list any of your child's special interests (color, sport, cartoon…)

_____

I understand the information given is correct to the best of my knowledge, and if there is any change in my child's health, I will inform the doctors at the next appointment without fail.

Signature of Parent/Guardian_____ Date _____ Relationship to Child _____