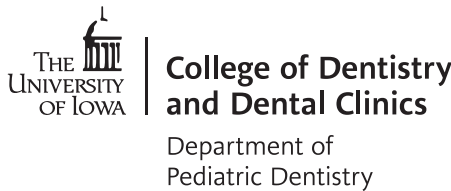


PEDIATRIC DENTAL HISTORY



REASON FOR VISIT:

Circle all reasons you are seeking dental care for your child? (Circle all that apply)

EXAMINATION

EMERGENCY

CONSULTATION

SECOND OPINION

OTHER: \_\_\_\_\_

PAST DENTAL TREATMENT:

YES

NO

DK

Has your child been to the dentist before? If yes, who \_\_\_\_\_

If yes, how long ago was his/her last dental exam? 

0-6 MONTHS

6-12 MONTHS

1-2 YEARS

> 2 YEARS

If yes, how long ago was his/her last dental x-ray? 

0-6 MONTHS

6-12 MONTHS

1-2 YEARS

> 2 YEARS

If yes, how long ago was his/her last dental cleaning? 

0-6 MONTHS

6-12 MONTHS

1-2 YEARS

> 2 YEARS

YES

NO

DK

Has your child ever had orthodontic (braces) treatment?

YES

NO

DK

Has your child had any problems associated with previous dental treatment?

If yes, specify: \_\_\_\_\_

DENTAL PROBLEMS:

YES

NO

DK

Is your child currently experiencing dental pain or discomfort?

YES

NO

DK

Is dental pain preventing your child from any of the following activities? (Circle all that apply)

EATING

DRINKING

SLEEPING

PERFORMING DAILY ACIVITIES (i.e. going to school)

YES

NO

DK

Are your child’s teeth sensitive to cold, hot, sweets or pressure? (Circle all that apply)

COLD

HOT

SWEETS

PRESSURE

YES

NO

DK

Does your child have any jaw problems? (Circle all that apply)

CLICKING

POPPING

DISCOMFORT

LIMITED OPENING

YES

NO

DK

Has your child ever had any injuries to their face, jaws, or teeth? If yes, specify: \_\_\_\_\_

YES

NO

DK

Are you or your child unhappy with the smile or the appearance of his/her teeth?

YES

NO

DK

Has fear prevented your child from receiving dental treatment?

YES

NO

DK

Do you have any concerns in regards to your child’s dental treatment or the dental materials used to treat your child?

If yes, specify: \_\_\_\_\_

ORAL HABITS:

YES

NO

DK

Does your child have a finger, thumb or pacifier habit? (Specify): 

FINGER

THUMB

PACIFIER

YES

NO

DK

Does your child clench or grind their teeth? (Specify): 

CLENCH

BRUX/GRIND

BOTH

YES

NO

DK

Does your child chew on ice or objects? (Specify): 

ICE

OBJECTS

BOTH

YES

NO

DK

Does your child have any other oral habits? If yes, specify: \_\_\_\_\_

FAMILY DENTAL HISTORY:

YES

NO

DK

Does your child have siblings with untreated cavities?

YES

NO

DK

Does either parent currently have untreated cavities?



PEDIATRIC MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Today’s Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of person completing health questionnaire: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Please circle your responses to questions below (Yes, No, DK (Don’t know)) to indicate if the patient has had any of the following diseases or problems.

GENERAL MEDICAL INFORMATION:

YES

NO

DK

Does your child have any health problems?

YES

NO

DK

Is your child currently under the care of a physician? If yes, for what \_\_\_\_\_

YES

NO

DK

Has your child had any serious illness, operation, or been hospitalized in the past 5 years? If yes, how long ago?

☐ 0-6 MONTHS

☐ 6-12 MONTHS

☐ 1-2 YEARS

☐ OVER 2 YEARS

Please specify: \_\_\_\_\_

YES

NO

DK

Has your child ever had any radiation therapy or chemotherapy for a growth, tumor or other condition?

☐ Radiation

Explain: \_\_\_\_\_

☐ Chemotherapy

Explain: \_\_\_\_\_

Physician List – Please list all medical specialists your child sees (including their primary care provider)

Name	City	Medical Facility	Type of Specialty

PRENATAL/NATAL HISTORY (Age 5 and younger ONLY):

YES

NO

DK

Did the birth mother have any problems during pregnancy or at birth?

If Yes, please explain: \_\_\_\_\_

YES

NO

DK

Did the birth mother take any medications during pregnancy?

If Yes, please explain: \_\_\_\_\_

YES

NO

DK

Was the child born prematurely?

If Yes, please explain: \_\_\_\_\_

YES

NO

DK

Were there any problems at birth for the child?

If Yes, please explain: \_\_\_\_\_

YES

NO

DK

Did the child take any medications during the first year of life?

If Yes, please explain: \_\_\_\_\_

ADOLESCENTS (Age 12 and older):

YES

NO

DK

Does your child currently use or has, in the past, used tobacco (smoking, e-cigarettes, snuff, chew, bidis)?

(Specify): 

☐ PAST

☐ CURRENT

 Type: \_\_\_\_\_

YES

NO

DK

Does your child drink alcoholic beverages?

YES

NO

DK

Does your child use prescription drugs, street drugs, or other substances for recreational purposes?

(Specify): 

☐ PAST

☐ CURRENT

 Type: \_\_\_\_\_

ADOLESCENT FEMALES ONLY (Age 12 and older):

YES

NO

DK

Are you or could you be pregnant? If you are pregnant, number of weeks: \_\_\_\_\_

YES

NO

DK

Are you nursing?

YES

NO

DK

Are you taking birth control pills?

FOR OFFICE USE ONLY:

Blood Pressure: \_\_\_\_\_/\_\_\_\_\_ Patient’s height in Feet: \_\_\_\_\_ Inches: \_\_\_\_\_ Patient’s weight: \_\_\_\_\_

