PEDIATRIC DENTAL HISTORY

The University of Iowa | College of Dentistry and Dental Clinics
Department of Pediatric Dentistry

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?

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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:** _____

MEDICAL CONDITIONS:

Does your child have or ever had any of the following diseases, problems, or symptoms?

YES NO DK Cardiovascular problems
If yes, please specify:
- ☐ Angina (chest pain)
- ☐ Arrhythmia
- ☐ Artificial heart valves
- ☐ Congenital heart defect/disease
- ☐ Coronary artery disease
- ☐ Heart attack
- ☐ Heart failure
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Implanted defibrillator
- ☐ Infective endocarditis
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Other (Specify): _____

YES NO DK Respiratory problems
If yes, please specify:
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD (Pulmonary Disease)
- ☐ Cystic fibrosis
- ☐ Emphysema
- ☐ Obstructive sleep apnea (OSA)
- ☐ Pneumonia
- ☐ Sinusitis
- ☐ Snoring
- ☐ Tuberculosis
- ☐ Other (Specify): _____

YES NO DK Endocrine disorders
If yes, please specify:
- ☐ Diabetes - Type I
- ☐ Diabetes – Type II
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Other (Specify): _____

YES NO DK Kidney disorders
If yes, please specify:
- ☐ Bladder problems
- ☐ Chronic kidney disease
- ☐ Dialysis
- ☐ Renal failure
- ☐ Urinary incontinence
- ☐ Other (Specify): _____

YES NO DK History of Cancer or Tumors
If yes, please specify:

_____
_____
_____
_____
_____

YES NO DK Behavioral, Developmental, or Mental Health disorders
If yes, please specify:
- ☐ Autism spectrum disorder (ASD)
- ☐ ADD/ADHD
- ☐ Anxiety disorder
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Down syndrome
- ☐ Intellectual disability
- ☐ Obsessive compulsive disorder (OCD)
- ☐ Oppositional defiant disorder (ODD)
- ☐ Panic attacks
- ☐ Pervasive developmental disorder PDD)
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Schizophrenia
- ☐ Other (Specify): _____

YES NO DK Neurologic (Nerve) disorders
If yes, please specify:
- ☐ Cerebral palsy
- ☐ Fainting/Dizzy spells
- ☐ Headaches
- ☐ Multiple sclerosis
- ☐ Neuropathies (tingling, numbness)
- ☐ Parkinson's disease
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Transient ischemic attacks (TIA)
- ☐ Other (Specify): _____

YES NO DK Blood/Bleeding disorders
If yes, please specify:
- ☐ Anemia
- ☐ Bruise easily
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple myeloma
- ☐ Sickle cell disease
- ☐ Sickle cell trait
- ☐ Thrombocytopenia
- ☐ Von Willebrand disease
- ☐ Other (Specify): _____

YES NO DK Stomach, Intestine, or Liver disorders
If yes, please specify:
- ☐ Acid reflux (GERD)
- ☐ Celiac disease
- ☐ Cirrhosis
- ☐ Crohn's disease
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Inflammatory bowel disease (IBD)
- ☐ Jaundice
- ☐ Ulcerative colitis
- ☐ Ulcers
- ☐ Other (Specify): _____

YES NO DK Muscle, Bone, Connective Tissue or Immune disorders
If yes, please specify:
- ☐ Ehlers-Danlos syndrome
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Lupus erythematosus
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Sjogren's syndrome
- ☐ Other (Specify): _____

YES NO DK Infectious disease
If yes, please specify:
- ☐ Cold sores
- ☐ HIV/AIDS
- ☐ Sexually transmitted disease (STD)
- ☐ Other (Specify): _____

YES NO DK Ear, Eye, Nose or Throat problems
If yes, please specify:
- ☐ Glaucoma
- ☐ Hay fever/season allergies
- ☐ Hearing impairment
- ☐ Recurrent ear infections
- ☐ Vision problems
- ☐ Other (Specify): _____

YES NO DK Skin problem
If yes, please specify:

_____
_____
_____

YES NO DK Eating disorder
If yes, please specify:
- ☐ Anorexia
- ☐ Bulimia
- ☐ Other (Specify): _____

YES NO DK Does your child have any other problem, disease or condition not listed above?
If yes, please specify:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES:

YES NO DK Is your child allergic to or has your child had a reaction to any of the following? (Please specify reactions.)

- ☐ Local anesthetics (Lidocaine/Epinephrine) **Reaction:** _____
- ☐ Penicillin **Reaction:** _____
- ☐ Sulfa drugs **Reaction:** _____
- ☐ Other antibiotics (Specify): _____ **Reaction:** _____
- ☐ Acetaminophen (Tylenol) **Reaction:** _____
- ☐ Aspirin **Reaction:** _____
- ☐ Ibuprofen (Advil, Motrin) **Reaction:** _____
- ☐ Metals/Jewelry (nickel, chrome) **Reaction:** _____
- ☐ Latex (rubber) **Reaction:** _____
- ☐ Seasonal Allergies **Reaction:** _____
- ☐ Food Allergies (Specify): _____ **Reaction:** _____
- ☐ Other Allergies:
  - **(Specify):** _____ **Reaction:** _____
  - **(Specify):** _____ **Reaction:** _____
  - **(Specify):** _____ **Reaction:** _____

MEDICATIONS:

YES NO DK Is your child taking any medications (prescription, over the counter, diet supplements, vitamins, natural or herbal)? If yes, please specify as completely as possible below.

Medications or Supplements: *Prescription, Over the Counter, Diet supplements, vitamins (natural or herbal)*	**What is it taken for?**	**Dosage**	**How often is it taken?**	**Route**	**Any side effects?**