MOUNTAINS EDGE
PEDIATRIC DENTISTRY

## Patient Health History

Patient Name______________________________ Birth date: ____/____/____ Today's Date: ____/_____/______

Child's Physician__________________________________________________ Phone#:______._____._________

Who May We Thank For Referring You?

_______________________________________________________________________

Purpose of Today's Visit:

___________________________________________________________________________________________

Date of Last Dental Visit: _______/_________/__________ Previous Dentist: ______________________________

**Circle One**

1. Does your child have any specific medical condition - tuberculosis, cancer, cerebral palsy, etc.?
If so, please specify_________________________________________________________________________ 1. Yes No
2. Does your child have any special limitations either mental or physical?
If so, please specify_________________________________________________________________________ 2. Yes No
3. Has your child ever had an operation?_______________________________________________________
If so, please specify_________________________________________________________________________ 3. Yes No
4. Have you ever been told by a physician that your child had/has a heart murmur, rheumatic fever, or a shunt?
At what age_____ Was a cardiogram ever done? _____ Is antibiotic coverage needed for dental work?_____ 4. Yes No
5. Does your child have asthma or breathing problems? 5. Yes No
6. Does your child have a history of seizures? 6. Yes No
7. Has your child ever tested positive for Hepatitis or HIV? If so, please specify__________________________ 7. Yes No
8. Does your child have any allergies to Antibiotics 8. Yes No
Analgesics (aspirin, codeine) Yes No
Latex Yes No
Pollen, Grass, Dust Yes No
9. Is your child now taking any medicine? If so, please specify________________________________________ 9. Yes No
10. Does your child have any learning disabilities, ADD or ADHD? If so, please specify____________________ 10. Yes No
11. Has your child ever had a transfusion of whole blood or any blood products? ________________________ 11. Yes No
12. Does your child have any social difficulties? 12. Yes No
13. Is your child adopted? 13. Yes No
14. Is your child in foster care? 14. Yes No
15. Are parents separated, divorced, widowed or never married? (Question asked to aid in our understanding of emotional status of child) 15. Yes No
16. Has your child had a history of thumb sucking, finger sucking, lip sucking, pacifier use or nail biting?
If so, please explain_______________________________________________________________________ 16. Yes No
17. Was your child's pregnancy or delivery abnormal in any way? 17. Yes No
18. Was your child breast fed?______ Bottle fed?_______ Any difficulties? ______________________________ 18. Yes No
19. Has your child ever had a prolonged fever for any reason? 19. Yes No
20. Has your child ever had any unfavorable experience in a medical or dental office? 20. Yes No
21. Has your child ever had any injuries to the teeth, mouth, head or neck?
If so, please explain______________________________________________________________________ 21. Yes No
22. Has the child's natural parents ever had extensive tooth decay? 22. Yes No
23. Does your child brush his/her teeth at least twice per day? 23. Yes No
24. Has your child had a toothache lately? _______ If yes, was the toothache after eating? _______
Did it awaken the child from sleep? __________ 24. Yes No
25. How do you think your child will react to this dental visit?
Very poor? ______ Poor? ______ Well? ______ Very Well? ______ 25.
26. Are there any other conditions or concerns not listed here?
If so, please specify_______________________________________________________________________ 26. Yes No

_______________________________________________________ Date: ____/____/_____
Signature of Parent or Guardian