Pediatric Medical History

Child's legal name: _____ Preferred name: _____ Date of birth: ____/____/_____
Birth sex: ◯ M ◯ F Current gender identity: _____ Pronouns: _____ Race/Ethnicity: _____ Height: ____cm Weight: ____kg
Name/age and relationship of others living in the household: _____

Primary physician: _____ Address/phone: _____ Last visit: _____
Medical specialists: _____ Address/phone: _____ Last visit: _____

Is your child being treated by a physician at this time? Reason _____ ◯ YES ◯ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ◯ YES ◯ NO
List name, dose, frequency & date started: _____
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ◯ YES ◯ NO
List date & describe: _____
Has your child ever had a reaction to or problem with an anesthetic? Describe _____ ◯ YES ◯ NO
Have you been told your child needs antibiotics or another medicine before dental treatment? Reason _____ ◯ YES ◯ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____ ◯ YES ◯ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____ ◯ YES ◯ NO
Is your child up to date on immunizations against childhood diseases? ◯ YES ◯ NO
Is your child immunized against human papilloma virus (HPV)? ◯ YES ◯ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before or at birth, prematurity, inherited conditions, syndromes, or birth defects (such as cleft lip/palate) ◯ YES ◯ NO
Problems with physical growth or development ◯ YES ◯ NO
Sinusitis, chronic adenoid/tonsil infections ◯ YES ◯ NO
Sleep apnea, snoring, or mouth breathing ◯ YES ◯ NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease ◯ YES ◯ NO
Irregular heart beat or high blood pressure ◯ YES ◯ NO
Asthma, reactive airway disease, wheezing, or breathing problems ◯ YES ◯ NO
Cystic fibrosis ◯ YES ◯ NO
Frequent colds or coughs, or bronchitis; pneumonia ◯ YES ◯ NO
Frequent exposure to tobacco smoke ◯ YES ◯ NO
Jaundice, hepatitis, or liver problems ◯ YES ◯ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ◯ YES ◯ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions ◯ YES ◯ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder ◯ YES ◯ NO
Bladder or kidney problems; bedwetting ◯ YES ◯ NO
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis ◯ YES ◯ NO
Rash/hives, eczema, or skin problems ◯ YES ◯ NO
Impaired vision, visual processing, hearing, or speech ◯ YES ◯ NO
Developmental disorders, learning problems/delays, or intellectual disability ◯ YES ◯ NO
Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures ◯ YES ◯ NO
Autism/autism spectrum disorder or sensory integration disorder ◯ YES ◯ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness ◯ YES ◯ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) ◯ YES ◯ NO
Attention deficit/hyperactivity disorder (ADD/ADHD) ◯ YES ◯ NO
Behavioral, emotional, communication, or psychiatric problems/treatment ◯ YES ◯ NO
Abuse (physical, psychological, emotional, or sexual) or neglect ◯ YES ◯ NO
Diabetes, hyperglycemia, or hypoglycemia ◯ YES ◯ NO
Precocious puberty or hormonal problems ◯ YES ◯ NO
Thyroid or pituitary problems ◯ YES ◯ NO
Anemia, sickle cell disease/trait, or blood disorder ◯ YES ◯ NO
Hemophilia, bruising easily, or excessive bleeding ◯ YES ◯ NO
Transfusions or receiving blood products ◯ YES ◯ NO
Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant ◯ YES ◯ NO
Corona virus disease 2019 (COVID-19), cytomegalovirus (CMV), human immunodeficiency virus (HIV)/AIDS, methicillin resistant, staphylococcus aureus (MRSA), mononucleosis, scarlet fever, sexually transmitted disease (STD), or tuberculosis (TB) ◯ YES ◯ NO

PROVIDE DETAILS HERE: _____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? ◯ YES ◯ NO
If YES, describe _____