Pediatric Dental/Medical Questionnaire

Please complete all sections of this form. This pertinent information will assist us in providing the best quality care for your child.

Child's Name_____Nickname_____

Birth Date_____Age_____ Phone (best contact)_____

Father's Name_____Mother's Name_____

Legal Guardian (if applicable)_____

Any responsible adult (non-parent or legal guardian) whom you authorize to escort the child to and from a dental appointment and act as your agent during the appointment.

Child's School_____Grade_____

Child's Physician_____Phone_____

Date of Last Physical Exam_____

Child's Pets & Hobbies_____

Participates in sports/wears mouthguard_____

1. Purpose of today's visit: _____
   Has your child experienced or is he/she experiencing any of the following?

_____Toothache	_____Broken tooth	_____Thumb habit
_____Snoring	_____Cavities	_____Bleeding gums
_____Clenching/grinding	_____Lost fillings	_____Bad breath
_____Crooked teeth	_____Headaches	_____Sore spots in mouth
_____Jaw pain/limitations		

   Other_____

2. Past dental history of child: Circle either YES or NO

Is this the first visit to a dentist	YES	NO
If you child has been to a dentist before:		
Does your child go regularly to a dentist?	YES	NO

Were X-rays taken? YES NO

Has your child had accidents involving the teeth? YES NO

If yes, explain:

_____

Is there fluoride in your water supply? YES NO

Does your child take a fluoride supplement? YES NO

Does your child brush/floss his or her teeth? YES NO

How often? Brush_____Floss_____

Do you help your child brush/floss? YES NO

3. Birth History

Was your child born premature? YES NO

Were there any problems during the pregnancy? YES NO

If yes, what?_____

Did the mother take any medication during pregnancy? YES NO

If yes, what?_____

Did your child exhibit any birth defects? YES NO

If yes, what?_____

Did your child require any special medical care after delivery? YES NO

If yes, what?_____

Is your child adopted?(for evaluation of hereditary factors) YES NO

Any other pertinent information_____

_____

4. Growth and Development:

Have there been any concerns about your child's physical development? YES NO

If yes, what?_____

Did your child ever repeatedly nap/sleep while nursing or drinking a bottle? YES NO

If yes, until what age?_____

Does your child:	Suck fingers or thumb?	YES	NO
	Use a pacifier?	YES	NO
	Lip bite or suck?	YES	NO
	Tongue thrust?	YES	NO
	Breathe through his/her mouth?	YES	NO
	Snore?	YES	NO
	Clench/grind teeth?	YES	NO
	Have any speech concerns?	YES	NO

5. General Health:

Does your child have regular medical check-ups? YES NO

Is your child being treated by a physician now? YES NO

If yes, for what reason?_____

Does your child have any chronic or long-term medical concerns? YES NO

If yes, what?_____

Is your child taking any medication? (prescription/non-prescription drugs) YES NO

If yes, what?_____

Has your child had any unfavorable reaction to medication, including antibiotics and local anesthetics? YES NO

If yes, specify?_____

Does your child bruise easily? YES NO

Does your child bleed excessively when cut? YES NO

Has your child ever been hospitalized? YES NO

If yes, why?_____

Has your child sustained any significant injuries? YES NO

If yes, what?_____

Does your child have, or has ever had (please give age)

Measles_____ Frequent headaches_____

Mumps_____ Bleeding problems_____

Chicken pox_____ Blood disorders_____

Whooping cough_____ Heart disorders_____

Rheumatic fever_____ Heart murmur_____

Asthma_____ Liver disease_____

Diabetes_____ Seizures_____

Digestive disorders_____ Frequent colds_____

Eye problems_____ Ear infections_____

Hepatitis_____ Cancer/tumors_____

HIV_____ Frequent infections_____

Tuberculosis_____ Sinus problems_____

Breathing problems_____ Cyclic vomiting_____

Adrenal gland disorders_____ ADHD_____

Hearing problems_____ Allergies_____

Tonsils/adenoids removed_____

Are there any other problems not previously mentioned?

_____

6. Family History:

Is mother living?	YES	NO
Is father living?	YES	NO
Are parents living together?	YES	NO
Names and ages of siblings_____		
Does mother see dentist regularly?	YES	NO
Are mother's teeth and gums in good health?	YES	NO
Does mother have missing teeth?	YES	NO
Did mother have orthodontic treatment (braces)?	YES	NO
Does mother have dental anxiety?	YES	NO
Does father see dentist regularly?	YES	NO
Are father's teeth and gums in good health?	YES	NO
Does father have missing teeth?	YES	NO
Did father have orthodontic treatment (braces)?	YES	NO
Does father have dental anxiety?	YES	NO

_____

Signature Date