306. S. Baldwin Ave.
Marion, IN 46952

Pediatric Medical History

Child's Full Name: Preferred Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Height: Weight:	Date of last physical examination	Race/Ethnicity:
Name of primary physician	Address of primary physician	Phone number of primary physician
Name of medical specialist	Address of medical specialist	Phone number of medical specialist

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 been treated in an emergency room? ☐ Yes ☐ No
Does your child have any learning, behavioral, extreme nervousness, or communication problems? ☐ Yes ☐ No
Does your child have any special needs? If so, please list: _____

Allergies

Has your child ever had a reaction to or a problem with local or general anesthetics? ☐ Yes ☐ No
Is your child allergic to any medications? ☐ Yes ☐ No
Is your child allergic to any foods? If so, please list _____ ☐ Yes ☐ No
Has your child ever had a reaction or allergy to a sedative medication? ☐ Yes ☐ No
Has your child ever had a reaction or allergy to an antibiotic? ☐ 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

Growth and Development

During pregnancy, were there any complications or was your child premature at birth? ☐ Yes ☐ No
Does your child have any problems with physical growth or development? ☐ Yes ☐ No

Cardiovascular System

Does your child have any history of heart disease, heart murmurs, or heart damage? ☐ Yes ☐ No
Has your child had any history of heart surgery or been recommended to have heart surgery? ☐ Yes ☐ No
Does your child have any history of irregular heartbeats or high blood pressure? ☐ Yes ☐ No

Central Nervous System

Does your child have any history of cerebral palsy, brain injury, epilepsy, or convulsions/seizures? ☐ Yes ☐ No
If your child has a history of cerebral palsy, please list which type of cerebral palsy _____
Does your child have any history of autism/autism spectrum disorder? ☐ Yes ☐ No
Does your child have any sensory disorders? (Seeing, Hearing, Smelling, Tasting, Touch) ☐ Yes ☐ No
Does your child have any history of hydrocephaly or placement of a shunt? ☐ Yes ☐ No
If so, which type of shunt was placed? (ventriculoperitoneal, ventriculoatrial, ventriculovenous)
Does your child have any history of attention deficit/hyperactivity disorder (ADD/ADHD)? ☐ Yes ☐ No

Hematopoietic System

Does your child have any history of anemia or sickle cell disease? ☐ Yes ☐ No
Is your child more susceptible to infections than other children? ☐ Yes ☐ No
Has your child received blood transfusions or blood products? ☐ Yes ☐ No
Does your child have any history of hemophilia, bruising easily, or excessive bleeding? ☐ Yes ☐ No

Respiratory System

Does your child have any history of pneumonia? ☐ Yes ☐ No
Does your child have any history of cystic fibrosis? ☐ Yes ☐ No
Does your child have any history of asthma? If so, please list what triggers the asthma _____ ☐ Yes ☐ No
Does your child have any shortness of breath or difficulty breathing? ☐ Yes ☐ No

Gastrointestinal System

Does your child have any history of jaundice, hepatitis, or liver problems? ☐ Yes ☐ No
Does your child have any history of stomach or intestinal problems? ☐ Yes ☐ No
Does your child have any history of eating disorders? (anorexia nervosa or bulimia) ☐Yes ☐ No

Endocrine System

Does your child have any history of diabetes? ☐ Yes ☐ No
Does your child have any history of thyroid dysfunction or other glandular disorders? ☐ Yes ☐ No
Does your child have any history of precocious puberty or hormonal problems? ☐ Yes ☐ No

Skin

Does your child have any history of rash, hives, eczema or skin problems? ☐ Yes ☐ No
Does your child have any history of cold sores (herpes) or canker sores (aphthae)? ☐ Yes ☐ No

Orthopedic System

Does your child have any limitations of use of arms or legs? ☐ Yes ☐ No
Does your child have any history of arthritis, joint replacements, or other joint problems? ☐ Yes ☐ No
Does your child have any history of muscle weakness or muscular dystrophy? ☐ Yes ☐ No

Immunizations

Is your child presently up to date with all recommended immunizations by his/her pediatrician? ☐ Yes ☐ No
List the date of your child's last DTap/DTP/DT/Td: diphtheria, whooping cough, tetanus immunization? _____

Dental History

Does your child have a **toothache** or other **immediate dental problem**? ☐ Yes ☐ No

Does your child have a history of any of the following? For each YES response, please describe below.

Inherited Dental Characteristics	
Mouth Sores or fever blisters	
Bad breath	
Bleeding gums	
Cavities/decayed teeth	
Toothache*** (List present and past)**	
Injury to teeth, mouth or jaws	
Clenching or grinding of teeth	
Cavities/decayed teeth	
Jaw joint problems (popping, etc.)	
Excessive gagging	
Sucking habit after one year of age	

How often does your child brush his/her teeth? ___ times per _____ Does someone help your child to brush? ☐ Yes ☐ No
How often does your child floss his/her teeth? ☐ Never ☐ Sometimes ☐ Daily Does someone help your child to floss? ☐ Yes ☐ No
What toothpaste does your child use at home? _____
What is the source of your child's drinking water at home? ☐ City/Community supply ☐ Private well ☐ Bottled water
Do you use a water filtration system at home? ☐ Yes ☐ No (If yes, which kind?) _____
Please check all sources of fluoride your child receives:
☐Drinking water ☐ Toothpaste ☐ Over the counter rinse ☐ Prescription rinse/gel ☐ Prescription drops/tablets

☐ Fluoride treatment in the dental office ☐ Fluoride varnish by pediatrician/other practitioner ☐ Other: _____

Does your child regularly eat 3 meals each day? ☐ Yes ☐ No
Is your child on a special or restricted diet? ☐ Yes ☐ No (if yes, please describe) _____
Does your child have a diet that his high in sugars and starches? ☐ Yes ☐ No
How frequently does your child have the following?

Candy or sweets	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day
Chewing gum	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day
Snacks between meals	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day
Soft drinks	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day
Juice	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day
Sports drinks/Energy drinks	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day

Has your child ever been to a dentist? ☐ Yes ☐ No
Has your child had an unfavorable experience at the dentist? ☐ Yes ☐ No

Does your child participate in sports activities? ☐ Yes ☐ No
Does your child wear a mouthguard during these activities? ☐ Yes ☐ No
Are you nervous at all when you go to the dentist? ☐ Yes ☐ No

How do you expect your child will respond to dental treatment?

☐ Very well ☐ Fairly well ☐ Somewhat poorly ☐ Very poorly

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Doctor's Notes:

_____
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_____
_____
_____
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_____

_____ _____ _____ _____
Signature of parent/guardian Relationship to child Date Signature of Doctor