ROCHESTER PEDIATRIC DENTISTRY

Child's Name _____ Child's Date of Birth _____

Dental History (Please Circle Yes or No)

Is this your child's first visit to the dentist? Yes No

If no, when and where was the last visit? _____

Has your child experienced any unfavorable dental care? Yes No

Is your child anxious in the dental office? Yes No

Ever had any pain associated with face, jaws or teeth? Yes No

Ever had any injury to their teeth? Yes No

Ever had swollen or bleeding gums? Yes No

If yes to any of the above, please explain: _____

_____

_____

Does your child currently have any pain associated with face, jaws or teeth? Yes No

If yes, where is the pain located? _____

Is the pain caused by heat, cold or sweets? _____

Is the pain constant? _____

Does the pain wake the child up at night or prevent them from sleeping? _____

Does your child have any swelling of their face or gums? Yes No

Does your child have frequent lip or mouth blisters? Yes No

Is your child currently being breastfed? Yes No

Does your child use a sippy cup or bottle? Yes No

What does your child drink on a daily basis? (Please circle)

Water, Formula, White Milk, Juice, Chocolate Milk, Other _____

Has your child ever had any of the following habits? (Please circle)

Finger/thumbsucking, Lip/nail biting, Pacifier use, Mouthbreathing, Teeth Grinding

Are your child's teeth brushed daily? Yes No

Are your child's teeth flossed daily? Yes No

Do you assist your child in cleaning their teeth? Yes No

Is your child taking any form of fluoride? Yes No

If yes, what form? _____

(Continued on back)

Medical History (Please Circle Yes or No)

Name of Physician _____

Name of Clinic _____ City _____

Date of last physical _____ Results _____

Is your child in good health? Yes No

Was your child's birth normal? Yes No

Is your child up-to-date with his/her vaccinations? Yes No

Has your child ever been hospitalized or had surgery? Yes No

If yes, for what reason? _____

Is your child taking any medication? Yes No

If yes, please list medication, dosage and reason for taking: _____

_____

_____

Does your child have any allergies or had an unusual reaction to any medications, foods, food additives or other substances? Yes No

If yes, please explain: _____

_____

Is your child currently being treated by a physician? Yes No

If yes, for what reason? _____

Does your child have any behavioral concerns/diagnosis? Yes No

If yes, please explain: _____

_____

Have you ever been told that your child requires an antibiotic prior to dental treatment?

Yes No

Please circle if your child currently has or in the past has experienced any of the following:

Allergy to anesthetics	Hay fever	Metal rods or screws placed
Anemia	Hearing problems	Mumps or measles
Asthma	Heart disease/abnormality	Pregnancy
Autism	Heart murmur	Radiation/Chemotherapy
Bleeding disorders	Heart valve replacement	Reactive airway disease
Brain injury	Hepatitis	Respiratory syncytial virus
Cancer or leukemia	High blood pressure	Rheumatic fever
Cystic fibrosis	HIV infection	Seizures
Chicken pox	Kidney disease	Shunts
Diabetes	Joint replacement	Sinus problems
Eating disorder	Liver disease	Speech problems
Epilepsy	Lung problems	Tuberculosis
Eye disorder	Malignant hyperthermia	Tumors

Please list and explain any other health conditions that have affected or currently affect your child:

_____

_____

I acknowledge as this child's parent/guardian, that the above information is complete and true.

Signature_____ Date_____ Relationship to child _____