Whitney M. Frank, DDS

Pediatric First Visit Medical/Dental History Form

Patient Name_____________________________ **Name & Relationship of person filling out this form**_____________________________
Date of Birth _____________________ **Today's Date** _____________________

Although dental personnel primarily treat your child's mouth, the mouth is a part of the *entire* body. Health problems or medications could have an important relationship with the dental care your child will receive. Thank you in advance for answering the following questions.

Please list your child's family physician and any medical specialists they see at least once a year:

NAME	SPECIALTY	PHONE NUMBER

YES NO Do you consider your child to be in good health?
YES NO Is your child up to date on immunizations?

Please list any history of hospitalization or surgery and the date: ____
____

Do your child **currently have** or **ever had**:

YES NO Allergic reactions to: Latex Penicillin Codeine Local Anesthetics Metals Other: _______________
Reaction: ____
YES NO Lactose Intolerance or Food allergy
YES NO Dietary Restrictions
YES NO Heart Bypass, Stent or Artificial Heart Valve
YES NO Congenital heart defect, rheumatic fever or rheumatic heart disease
YES NO Irregular Heartbeat
YES NO High Blood Pressure
YES NO Cystic Fibrosis
YES NO Complications before or during birth
YES NO Pre-mature birth
YES NO Problems with growth or development
YES NO Any inherited condition
YES NO GERD or acid reflux
YES NO Bladder or Kidney Problems
YES NO Jaundice, Hepatitis or liver problems
YES NO Artificial implants or devices
YES NO Bleeding problem, clotting disorder, anemia or other blood disease
YES NO Diabetes Type I or Type II
YES NO Seizures or any other nervous system disease
YES NO Sinusitis, chronic adenoid/tonsil infections
YES NO Asthma
YES NO Sleep Apnea, snoring, mouth breathing
YES NO Cancer Type____
Chemotherapy (dates) __________________ Radiation (dates) ____________________
YES NO Immunosuppressive condition (circle those that apply)
Prednisone therapy Cancer therapy Spleen removed Rheumatoid Arthritis
HIV/AIDS Organ Transplant SLE (Lupus) Other: ____________________
YES NO Developmental or intellectual disorders
YES NO Impairment of hearing or sight or speech
YES NO Physical or mental condition that may require special care
YES NO Behavioral, emotional, communication or psychiatric problems/treatment
YES NO Abuse (physical, psychological, emotional or sexual) or neglect
YES NO Does your child have any disease, condition, or problem not listed here?
Please describe: ____

For any positive answer above that needs more description, use the space below:
____
____
____

Dental History

What is your primary concern about your child's oral health?____

What was your child's age in months when the first tooth appeared? _____________

Which of the following do you use to clean your child's teeth?

Toothbrush   Washcloth   Floss   Fluoride Toothpaste   Fluoride-Free Toothpaste   Other_____________

How often do you brush your child's teeth? ________ times per __________

How often do you floss your child's teeth? ________ times per __________

Who cleans your child's teeth?   Parent   Child   Caregiver   Other: _______________

What does your child drink out of? ___________________________________

Who takes care of your child? Circle all that apply:

Mother   Father   Grandparent   Sibling(s)   Daycare   Nanny   Babysitter   Other

Have any of the following had cavities in the past year? Circle any that apply:

Mother   Father   Grandparent   Sibling(s)   Frequent Caregiver

Are you eligible for any of the following government programs?

WIC   Head Start   Medicaid   SCHIP

If you could wave a magic wand and have one wish granted for your child's oral health, what would it be:

____

YES NO Does your child take fluoride supplements?

YES NO Does your child nap or sleep with a bottle? Contents:____________________

YES NO Was your child breast-fed? How long? _________________________________

Does your child currently have or have they ever had any of the following:

YES NO Dental exam   Approximate date? __________________________

YES NO Dental xrays

YES NO Dental treatment? Describe: ____

YES NO Injury to face or jaw

YES NO Lumps or sores inside the mouth

YES NO Cold sores or canker sores   Location:___________   How many times/year?_________________

YES NO Bleeding gums

YES NO Grinding or gritting of teeth

YES NO Jaw joint pain

YES NO Sucking habit beyond 1 year of age

Dietary Evaluation:

How frequently does your child consume the following types of foods/drinks?
(If possible, please provide specifics on the type of foods/drinks your child is *most commonly* consuming)

FOOD/DRINK	# TIMES/DAY	TYPE
Candy		
Snacks between meals		
Vegetables		
Fruit		
Chewing gum		
Milk		
Water		
Soft Drinks*		

*including juice, flavored drinks, sodas, carbonated drinks, energy drinks, sports drinks, sweetened beverages

Please list all medicines and supplements that your child is currently taking:

Date	Medicine or Supplement	Dose	Medical Condition	Date Discontinued *(for office use)*	Notes *(for office use)*

No persons outside of this office will be provided this information unless properly authorized by you or required by law. By signing below, you agree that the information given is accurate to your knowledge and that you will notify us of any changes at subsequent appointments.

Signature: ____ Date:______________________

Relationship to patient:_____________________________________