John M Schiefelbein, DMD, PLLC

Patient Name: _____ Nickname: _____ Birthdate: _____

PEDIATRIC DENTAL & MEDICAL HISTORY

Has your child ever had a serious or difficult problem associated with previous dental work: ❑Yes ❑No
If yes, please explain: _____

Has your child had any injuries to the mouth, teeth or head: ❑Yes ❑No
If yes, specify injury and date:_____

What is your child's attitude towards dentistry? ❑ Normal ❑ Shy ❑ Apprehensive ❑ Frightened

Does your child have any of the following habits/history:

Thumb/finger sucking/Pacifier	❑Yes ❑No	Frequent snacking	❑Yes ❑No	Tooth grinding	❑Yes ❑No
Sleeping with a bottle/sippy cup use	❑Yes ❑No	Mouth Breathing	❑Yes ❑No	Nail biting	❑Yes ❑No
Night-time feeding	❑Yes ❑No	Snoring	❑Yes ❑No	Ortho Treatment	❑Yes ❑No

HOME DENTAL CARE:

Teeth are brushed _____ times daily by	❑Parent ❑Child	Does your child take fluoride supplements?	❑Yes ❑No
Teeth are flossed ❑ daily ❑ weekly by	❑Parent ❑Child	Is your child able to spit?	❑Yes ❑No

Child's Physician/Clinic: _____ **Date of last medical exam**: _____

Is your child in good health? ❑Yes ❑ No Is your child currently under the care of a physician for any condition? ❑Yes ❑No
Please specify: _____

Has your child been hospitalized or required surgery? ❑Yes ❑No If yes, please explain: _____

_____

Have you been told by a physician that your child needs antibiotics prior to a dental procedure? ❑Yes ❑No If yes, please explain:

_____

MEDICATIONS: Is your child currently taking any prescription or over-the-counter medications/supplements? Please specify:

_____

MEDICATION ALLERGIES: ❑Yes ❑No if yes, medication name_____

_____

OTHER ALLERGIES: ❑Yes ❑No (i.e. food, latex, etc)_____

_____

Does your child have a history of, or difficulty with, any of the following?

ADD/ADHD	❑Yes ❑No	Drug Reactions	❑Yes ❑No	Liver Conditions	❑Yes ❑No
Asthma	❑Yes ❑No	Eating Disorder	❑Yes ❑No	Lung Disease	❑Yes ❑No
Autism or Similar Condition	❑Yes ❑No	Epilepsy or other Seizure Disorder	❑Yes ❑No	Pain / Sores	❑Yes ❑No
Blood Disorder	❑Yes ❑No	Hearing Impairment	❑Yes ❑No	Sickle Cell Anemia	❑Yes ❑No
Cancer	❑Yes ❑No	Heart Condition/Murmur	❑Yes ❑No	Speech Difficulties	❑Yes ❑No
Cerebral Palsy	❑Yes ❑No	Hepatitis/Other Blood-borne Pathogens	❑Yes ❑No	Thyroid	❑Yes ❑No
Congenital Birth Defects	❑Yes ❑No	HIV/AIDS	❑Yes ❑No	Tuberculosis	❑Yes ❑No
Developmental Delay	❑Yes ❑No	Kidney Conditions	❑Yes ❑No	Pregnancy (teens)	❑Yes ❑No
Diabetes	❑Yes ❑No	Learning/Intellectual Disability	❑Yes ❑No	B12 Deficiency	❑Yes ❑No

Additional Information: In the space below, please include and explain any further information we need to be aware of:

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Parent or Legal Guardian and relationship to patient: _____ **Date**: _____

Print Name: _____ (Office Use Only) Initials: _____ Date: _____

If additional space is needed, please use the back of this form.