ROCHESTER DENTAL CLINIC
Patient focused, Family Friendly

Pediatric Medical & Dental History

Patient Name_____Nickname_____Age_____ Gender ☐M ☐F

Name of Physician & Date of last physical examination_____

Antibiotic PRE-MED: Does your child require antibiotics prior to dental treatment? ☐ Yes ☐ No
Is this your child's first visit to a dentist? ☐ Yes ☐ No Date of your child's last dental exam_____
Has your child had dental radiographs in the last year? ☐ Yes ☐ No

Has your child have or ever had?

		Yes	No
1.	hospitalization for illness or injury	☐	☐
2.	an allergic reaction to:	☐	☐
	☐ aspirin, ibuprofen, acetaminophen, codeine		
	☐ penicillin ☐ latex		
	☐ other antibiotics ☐ food		
	☐ local anesthetic		
	☐ metals (nickel, gold, silver)		
	☐ food		
	☐ other_____		
3.	heart problems	☐	☐
4.	history of infective endocarditus	☐	☐
5.	artificial heart valve, repaired heart defect	☐	☐
6.	high or low blood pressure	☐	☐
7.	anemia or other blood disorder	☐	☐
8.	prolonged bleeding due to a slight cut (INR >3.5)	☐	☐
9.	tuberculosis	☐	☐
10.	asthma	☐	☐
11.	breathing or sleep problems (i.e. snoring, sinus)	☐	☐
12.	kidney disease	☐	☐
13.	liver disease	☐	☐
14.	thyroid	☐	☐
15.	diabetes	☐	☐
16.	digestive disorders (i.e. heartburn or gastric reflux)	☐	☐
17.	injuries to the head, neck, teeth or face	☐	☐
18.	epilepsy, convulsions	☐	☐
19.	hepatitis or HIV/AIDS	☐	☐
20.	tumor or abnormal growth	☐	☐
21.	radiation or chemotherapy	☐	☐
22.	psychiatric treatment	☐	☐
23.	often unhappy, depressed or emotionally impaired	☐	☐
24.	substance abuse	☐	☐
25.	frequent headaches	☐	☐

		Yes	No
26.	tonsils and/or adenoids removed Yes, at what age_____	☐	☐
27.	Does your child have any problems with: ☐ concentrating ☐ learning ☐ cooperating ☐ sensitive to sounds, bright ☐ understanding lights, etc		
28.	Do you feel your child will be a cooperative patient?	☐	☐
29.	viral infections and cold sores	☐	☐
30.	speech difficulties	☐	☐
31.	problems with dental visits in the past	☐	☐
32.	any lumps or swelling in the mouth	☐	☐
33.	problems with the eruption or shedding of teeth	☐	☐
34.	orthodontic treatment	☐	☐
35.	if yes, name of orthodontist and date of treatment	☐	☐
36.	what type of water does your child drink? ☐ city water ☐ bottled water ☐ well water ☐ filtered water		
37.	does your child take fluoride supplements	☐	☐
38.	is fluoride toothpaste used	☐	☐
39.	how many times a day and when are the child's teeth brushed_____		
40.	do you assist your child with tooth brushing	☐	☐
41.	does your child suck their thumb, fingers or pacifier	☐	☐
42.	does the child participate in active recreational activities	☐	☐
43.	What are specific concerns for your child's teeth? _____ _____		

_____

Describe any serious illness, medical treatment, impending surgery, genetic / developmental anomalies, or other medical concerns that may possibly affect your dental treatment.

_____

Drug / Dose Drug / Dose

Please advice us in the future of any change in your medical history or any medications the patient may be taking

Parent or Guardian's Signature_____Date_____

Doctor's Signature_____Date_____