LAHAIR & GALLAGHER
PEDIATRIC DENTISTRY, LLC
Saving the world one tooth at a time

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Medical & Dental History

Child's Name: _____ Sex: _____ Height: _____ Weight: _____ Date of Birth: _____

Date of last medical examination: _____ Child's Physician/Pediatrician: _____ Telephone: _____

Siblings: _____

Growth and Development:

Any learning, behavioral, excessive nervousness or communication problems?	YES [ ] NO [ ]
Has child had psychological counseling or is counseling being considered for the near future?	YES [ ] NO [ ]
Were there any complications during pregnancy or was child premature at birth?	YES [ ] NO [ ]

Central Nervous System:

Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness?	YES [ ] NO [ ]
Any history of head injury?	YES [ ] NO [ ]
Any sensory disorders?(seeing, hearing)	YES [ ] NO [ ]

Cardiovascular System:

Any history of congenital heart disease, heart murmur, or heart damage from rheumatic fever?	YES [ ] NO [ ]
Has any heart surgery been done or recommended?	YES [ ] NO [ ]
Any history of chest pains or high blood pressure?	YES [ ] NO [ ]

Hematopoietic and Lymphatic Systems:

Has your child ever had a blood transfusion or blood products transfusion?	YES [ ] NO [ ]
Any history of anemia or sickle cell disease?	YES [ ] NO [ ]
Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts?	YES [ ] NO [ ]
Is your child more susceptible to infections than other children?	YES [ ] NO [ ]
Is there any history of tender or swollen lymph nodes or glands?	YES [ ] NO [ ]

Respiratory System:

Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty in breathing?	YES [ ] NO [ ]

Gastrointestinal System:

Any history of stomach, intestinal, or liver problems?	YES [ ] NO [ ]
Any history of hepatitis or jaundice?	YES [ ] NO [ ]
Any history of eating disorders, such as anorexia nervosa (binge) or bulimia (binge/purge)?	YES [ ] NO [ ]

Genitourinary System:

Any history of urinary tract infections, bladder or kidney problems?	YES [ ] NO [ ]
Is the patient pregnant or possibly pregnant?	YES [ ] NO [ ]

Endocrine System:

Any history of diabetes?	YES [ ] NO [ ]
Any history of thyroid disorders or other glandular disorders?	YES [ ] NO [ ]

Skin:

Any history of skin problem, cold sores (herpes), or canker sores (apthae)?	YES [ ] NO [ ]

Extremities:

Any limitations of use of arms or legs?	YES [ ] NO [ ]
Any arthritis, joints bleeding, joint replacements, or other joint problems?	YES [ ] NO [ ]

Allergies:

Is your child allergic to any medications?	YES [ ] NO [ ]
Any hay fever, hives, or skin rashes caused by allergies?	YES [ ] NO [ ]
Any other allergies?	YES [ ] NO [ ]

Medications and Treatments:

Is your child currently taking any medication (prescription or non-prescription medicine?) YES [ ] NO [ ]

If yes, Medication(s) Dosage (mg) Times per day

_____ _____ _____

_____ _____ _____

_____ _____ _____

Has your child ever received therapy (x-ray treatments) or is planned? YES [ ] NO [ ]

Has your child ever received chemotherapy or is it planned? YES [ ] NO [ ]

Hospitalizations:

Has your child been hospitalized? YES [ ] NO [ ]

Hospital (1) _____ (2) _____ (3) _____

Date _____ _____ _____

Reason _____ _____ _____

Is your child's Immunizations up to date? YES [ ] NO [ ]

Dental History:

Does your child have a toothache or other immediate problem? YES [ ] NO [ ]

Has your child ever had a toothache? YES [ ] NO [ ]

Has your child had any injury to the mouth, teeth or jaws (fall, blow, etc.) When: _____ YES [ ] NO [ ]

Is this your child's first dental visit? YES [ ] NO [ ]

*If no, please tell us: First visit: _____Dentist_____Reason:_____

Last visit: _____Dentist_____Reason_____

Has your child ever had an unfavorable dental visit? YES [ ] NO [ ]

Is (was) your child nourished by nursing beyond one year of age? YES [ ] NO [ ]

Please let us know how your child was nourished? [ ] Breast [ ] Nursing Bottle [ ] Both To what age? _____

Does your child fail to eat a well balanced diet? YES [ ] NO [ ]

Please describe your child's diet on a typical day: _____

Does (or has) your child have (or had) sucking habit beyond one year of age? YES [ ] NO [ ]

If yes please check all that apply: [ ] thumb [ ] finger [ ] pacifier [ ] other_____

Does (or has) your child have (or had) any other oral habits beyond one year of age? YES [ ] NO [ ]

If yes, please check all that apply: [ ] lip biting [ ] mouth breather [ ] nail biting [ ] teeth grinding [ ] other

Does (or has) your child have (or had) popping or clicking noises or pain during chewing or yawning? YES [ ] NO [ ]

Does your child have or had frequent headaches or pain in or about the ears, eyes, or cheeks? YES [ ] NO [ ]

Dental Disease Prevention:

How often does your child brush? (Times per Day)_____

Does someone assist your child with brushing and cleaning the teeth? (Who helps)_____ YES [ ] NO [ ]

Does someone inspect for thoroughness after the procedure? (Who inspects)_____ YES [ ] NO [ ]

Does your child use a fluoride toothpaste? (What brand)_____ YES [ ] NO [ ]

Does your child use dental floss? (How often)_____ YES [ ] NO [ ]

Has your child had a fluoride treatment? (When)_____ YES [ ] NO [ ]

Has your child ever taken a fluoride supplement or vitamins with fluoride? (When)_____ YES [ ] NO [ ]

Drinking water source:

CITY WATER [ ] Name of City _____

PRIVATE WELL [ ] Has a fluoride analysis been done? Y/N Date of analysis: _____ Fluoride content: _____

OTHER [ ] Please Describe: _____

_____ _____

SIGNATURE (Parent or Legal Guardian only) *SIGNATURE PEDIATRIC DENTIST* *DATE*

Semi-Annual Review of Medical-Dental History: If history remains essentially unchanged, sign below.

DATE: _____PARENT/GAURDIAN: _____DENTIST:_____

DATE: _____PARENT/GAURDIAN: _____DENTIST: _____

DATE: _____PARENT/GAURDIAN: _____DENTIST: _____

A new history form must be completed every 2 years for Essentially Negative or every 1 year for Positive History