Pediatric Dental Associates Health Form

Child's Name: _____ Nickname: _____ Gender: ☐ M ☐ F ☐ Nonbinary
Age:_____ Birth Date: _____ Pronouns: _____ Hobbies/Interests/Pets: _____
Mailing Address: _____ City:_____ State: ___ Zip: _____
Home Telephone: _____ Cell Phone: _____ Email: _____
Whom may we thank for referring you? _____

Child's Physician/Pediatrician: _____ Phone: _____
Address: _____ Child's Previous Dentist: _____

Do you have any concerns about your child's teeth? _____

Medical History

Were there any difficulties during the pregnancy, delivery (e.g. prematurity) or 1st year of your child's life? ☐ Yes ☐ No
If yes, describe. _____
Was your child bottle fed? ☐ Yes ☐ No If yes, until what age? _____ Any difficulty with bottle feeding? ☐ Yes ☐ No
Was your child breast fed? ☐ Yes ☐ No If yes, until what age? _____ Any difficulty latching? ☐ Yes ☐ No
Has your child had any frenectomies? ☐ Yes ☐ No If yes, date and provider: _____

Does your child have any history of the following? (*Check all that apply.)*

☐ ADHD	☐ Anemia	☐ Anxiety/Nervousness	☐ Arthritis/Bone/Joint Issues	☐ Asthma/Reactive Airway
☐ Autism	☐ Behavior Issues	☐ Bladder/Kidney Issues	☐ Bleeding (prolonged)	☐ Blood Transfusion
☐ Brain Injury/Stroke	☐ Cancer _____	☐ Cerebral Palsy	☐ Cleft Lip/Palate	☐ Communication Issues
☐ COVID-19/RSV	☐ Cystic Fibrosis	☐ Developmental Delay	☐ Diabetes	☐ Ear Infections/Ear Tubes
☐ Emotional Disability	☐ Feeding Problems	☐ Gastrointestinal Disorders (Celiac/Crohn's, GERD)		☐ Growth Problems
☐ Headaches/Migraines	☐ Hearing Loss	☐ Heart Disease	☐ Heart Murmur	☐ Hemophilia
☐ Hepatitis/Jaundice	☐ HIV/AIDS	☐ Learning Disability	☐ Neuromuscular Defects	☐ Orthopedic Problems
☐ Psychiatric Disorder	☐ Rheumatic Fever	☐ Scarlet Fever:	☐ Seizures/Epilepsy	☐ Sensory Integration
☐ Sickle Cell Disease/Trait	☐ Sinus/Adenoids/Tonsils	☐ Skin (Eczema/Rash/Hives)	☐ Sleep Apnea	☐ Sleep Problems/Snoring
☐ Speech Problems	☐ Spina Bifida	☐ Thyroid disorder	☐ Tobacco/Vaping/Drug use	☐ Tuberculosis
☐ Syndrome: _____		☐ Other: _____		☐ Abuse (physical/sexual)

If any boxes are checked, please describe further: _____
_____
_____

Is your child CURRENTLY taking any medications? ☐ Yes ☐ No

Drug	*Dose*	*Frequency*	*Reason*

Has your child had any allergic reactions to: Medications? ☐ Yes ☐ No _____ Latex? ☐ Yes ☐ No
Foods? ☐ Yes ☐ No _____ Other? _____

Development/Special Needs:
Can your child speak and understand at his/her age level? ☐ Yes ☐ No
Does your child attend a special class or school? _____ ☐ Yes ☐ No
Are your child's immunizations current? ☐ Yes ☐ No

Does your child need to take antibiotics before dental treatment? ☐ Yes ☐ No

Has your child ever been hospitalized? ☐ Yes ☐ No
When? _____ Where? _____ Reason? _____

Has your child had any surgery? ☐ Yes ☐ No
When? _____ Why? _____ Was general anesthesia used? ☐ Yes ☐ No
Any complications? _____

Dental History

Why is your child here today? _____

If your child has been to a dentist: Date of last visit _____ Have X-rays been taken? ☐ Yes ☐ No ☐ Unsure
How did your child react? _____

How would you describe your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Is there a family history of cavities? ☐ Yes ☐ No If yes, indicate all that apply: ☐ Mother ☐ Father ☐ Sibling

Is fluoride taken in any of the following forms?
Fluoride tablets, drops, or multivitamins ☐ Yes ☐ No Drinking water ☐ Yes ☐ No
Toothpaste ☐ Yes ☐ No Fluoride rinse ☐ Yes ☐ No

How often do your child's teeth get brushed? # of times/day _____ Does someone help your child brush? ☐ Yes ☐ No
When does your child brush? ☐ AM ☐ PM ☐ After meals
How often do your child's teeth get flossed? # of times/day _____ Does someone help your child floss? ☐ Yes ☐ No
What kind of toothbrush does your child use? ☐ Manual ☐ Battery-powered/Electric
What toothpaste does your child use? _____
Does your child swallow toothpaste? ☐ Yes ☐ No ☐ Unsure

Does your child regularly eat 3 meals each day? ☐ Yes ☐ No
Does your child snack frequently? ☐ Yes ☐ No # of times/day _____
What does your child typically snack on? _____
Is your child on a special or restricted diet? ☐ Yes ☐ No Describe: _____
Is your child a picky eater? ☐ Yes ☐ No
Is your child a slow eater? ☐ Yes ☐ No
Does your child drink juice? ☐ Yes ☐ No How much? _____
Does your child drink soda? ☐ Yes ☐ No How much? _____
Does your child drink seltzer or flavored water? ☐ Yes ☐ No How much? _____
Does your child drink sports drinks? ☐ Yes ☐ No How much? _____
Does your child drink energy drinks or coffee? ☐ Yes ☐ No How much? _____
Does your child chew gum? ☐ Yes ☐ No Is it sugar free? ☐ Yes ☐ No ☐ Unsure

Have your child's teeth ever been injured? ☐ Yes ☐ No When (age)? _____
Which teeth? _____ Injury? _____
Treatment? _____

Does your child have any of the following habits? (Please check all that apply)
☐ Pacifier ☐ Thumb Sucking ☐ Finger Sucking ☐ Grinding ☐ Snoring
☐ Mouth Breathing ☐ Tongue Thrust ☐ Lip Sucking ☐ Open Mouth Posturing ☐ Nail Biting
☐ Excessive Gagging ☐ Holding Food in Mouth ☐ Bottle to Sleep or Nap ☐ Walking Around with a Sippy Cup or Bottle

Has your child had any unhappy dental experiences? ☐ Yes ☐ No Please explain. _____
_____

Is there anything else you'd like to tell us? _____
_____

Parent Signature: _____ Relationship to Patient: _____ Date: _____

Reviewed by:_____