# OHSU School of Dentistry Department of Pediatric Dentistry Medical History

**DATE:** _____ **CHILD'S NAME:** _____

**1) What city does your child live in?** _____ **State:** _____ **Zip Code:** _____

**2) What is your child's nickname?** _____ **What gender is your child? Male Female Transgender**

**3) Who does your child live with? Mother Father Both Parents Grandparents Foster Parent Guardian**

**Is this the legal guardian for this child? Yes No Name of legal guardian:** _____

**4) What are your child's hobbies?** _____

**5) What are the names/ages of other children in the family?** _____

**6) Do you have any special concerns to bring up at this visit? YES NO** _____

**7) Has your child complained about tooth pain or dental problems? YES NO** _____

**8) Is this your child's first visit to the dentist? YES NO**

**If no, when was your child's last visit with a dentist?** _____

**If no, what was the reason for the last dental visit?** _____

**9) How is your child's overall health? Very Poor Poor Average Excellent**

**10) Does your child have any medical problems? YES NO DON'T KNOW** _____

**11) Did your child have any problems at birth, shortly after birth or was your child born prematurely? YES NO**

_____

**12) Has your child had any hospitalizations or surgeries, hospital procedures or been seriously injured? YES NO**

_____

**13) Has your child had any injuries to the mouth, teeth or head? YES NO**

_____

**14) Has your child had any general anesthetics (put asleep)? YES NO DON'T KNOW** _____

**15) Has your child had any emotionally or physically traumatic experiences that you feel would be helpful for us to know about?**

**Any unhappy dental experiences? YES NO DON'T KNOW** _____

**16) Does your child have behavior problems or problems cooperating or paying attention? YES NO**

_____

**17) Is there any other information you would like us to know about your child? YES NO**

_____

## MEDICAL CONDITIONS

**18) Has your child had or does your child have any of the following medical conditions?**

- ☐ ADHD/Attention Deficit
- ☐ Anemia/blood problem
- ☐ Asthma or breathing problems
- ☐ Autism/Autism Spectrum
- ☐ Bleeding or bruising problems
- ☐ Blindness
- ☐ Cancer/Leukemia
- ☐ Cerebral Palsy
- ☐ Deafness
- ☐ Diabetes
- ☐ Frequent colds
- ☐ G-tube
- ☐ Heart disease or murmurs
- ☐ Immune system problems
- ☐ Kidney disease
- ☐ Liver disease/jaundice/hepatitis
- ☐ Lung disease
- ☐ Muscle weakness/disease
- ☐ Organ Transplant
- ☐ Rheumatic fever
- ☐ Seizure Disorder
- ☐ Spine problems/surgery
- ☐ Stomach/Intestinal/GI reflux problems
- ☐ Swallowing difficulty
- ☐ Syndrome _____
- ☐ Tracheostomy
- ☐ Tuberculosis
- ☐ Other

**19) Is your child up to date on recommended vaccinations?" Yes No**

**20) Does your child snore? Yes No**

**21) Is there any chance your child could be/is pregnant? Yes No Don't Know**

**22) Is your child emotionally or physically disabled or challenged or developmentally delayed?**

**23) Does your child have any speech or language delay?**

## MEDICATIONS

**24) Does your child take any medications including herbs, pain medication or birth control pills? Yes No**

**Please List:** _____

## ALLERGIES/MEDICATION PROBLEMS

**25) Has your child, or does your child, have any of the following allergies or medication problems?**

- ☐ Latex
- ☐ Penicillin or amoxicillin
- ☐ Sulfa
- ☐ Other medication problems/drug allergy _____
- ☐ Other allergy of any kind (including foods) _____

**26) Do any of your child's family members have an anesthetic allergy or malignant hyperthermia? YES NO DON'T KNOW**

# PEDS Dental History/Home Care

**1) How often does your child visit the dentist? (a)** About every 12 months **(b)** About every 6 months

**(c)** Only when my child has a mouth problem (d) This is my child's first to the dentist

**2) What is your child's use of fluoride?** **(a)**Toothpaste **(b)** Water supply (city water) **(c)** Supplement (tablet or drops)

**(d)** Rinse **(e)** None

**3) How often are your child's teeth brushed? (a)** Two times daily **(b)** Once a day in the morning

**(c)** Once a day before going to bed **(d)** Less than once a day

**4) Who brushes your child's teeth (select all that apply)?**

- ☐ Child
- ☐ Parent
- ☐ Other: _____

**5) Has your child taken antibiotic medications in the past 3 months? YES NO**

**If yes, please list the name of the medication and reason for taking:** _____

**6) How often does your child have snacks? (a)** No snacks (b) One time daily **(c)** Two times daily **(d)** Three or more times daily

**7) Please list three of your child's favorite between-meal snacks:** _____

**8) How often does your child drink beverages other than milk or water? (a)** One time daily **(b)** Two times daily

**(c)** Three or more times daily **(d)** Almost never/none

**9) Please list your child's favorite beverage:** _____

**10) How important is it TO YOU for your child's teeth to be healthy? (a)** Very important **(b)** Somewhat important

**(c)** Not important **(d)** I don't know if it is important

**11) How old was your child when the first baby tooth came in? (a)** Less than 6 months old **(b)** 6-12 months old

**(c)** Older than 12 months **(d)** I cannot exactly remember

**12) Does your child nurse or drink from a bottle? YES NO** _____

**13) Does your child use a sippy cup? YES NO**

**14) Does/did your child use a pacifier or suck a thumb or finger? YES NO** _____

**15) Has your child worn orthodontic braces or orthodontic appliances? YES NO** _____