School of DENTISTRY
OHSU

Chart # _____

Department of Pediatric Dentistry

Medical History

CHILD'S NAME: _____ DATE: _____

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

What is your child's nickname? _____ What gender is your child? ☐ Male ☐ Female ☐ Transgender

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: _____

What are your child's hobbies? _____

_____

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

_____

Do you have any special concerns to bring up at this visit? ☐ YES ☐ NO

_____

Has your child complained about tooth pain or dental problems? ☐ YES ☐ NO

_____

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? _____

How is your child's overall health? ☐ Very Poor ☐ Poor ☐ Average ☐ Excellent

Does your child have any medical problems? ☐ YES ☐ NO ☐ DON'T KNOW

_____

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

_____

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

_____

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

_____

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

_____

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 _____

_____

Does your child have behavior problems or problems cooperating or paying attention? ☐ YES ☐ NO

_____

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

_____

_____

_____

School of DENTISTRY
OHSU

Department of Pediatric Dentistry

Chart # _____

MEDICAL CONDITIONS

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 _____

Is your child up to date on recommended vaccinations? ☐ Yes ☐ No

Does your child snore? ☐ Yes ☐ No

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

Is your child emotionally or physically disabled or challenged or developmentally delayed? ☐ Yes ☐ No

_____

Does your child have any speech or language delay? ☐ Yes ☐ No

_____

MEDICATIONS

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

Please List: _____

ALLERGIES/MEDICATION PROBLEMS

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) _____

Do any of your child's family members have an anesthetic allergy or malignant hyperthermia? ☐ Yes ☐ No
☐ DON'T KNOW _____

School of DENTISTRY
OHSU

Chart # _____

Department of Pediatric Dentistry

Dental History/Home Care

How often does your child visit the dentist? ○ About every 12 months ○ About every 6 months
○ Only when my child has a mouth problem ○ This is my child's first to the dentist
What is your child's use of fluoride? ○ Toothpaste ○ Water supply (city water) ○ Supplement (tablet or drops)
○ Rinse ○ None
How often are your child's teeth brushed? ○ Two times daily ○ Once a day in the morning
○ Once a day before going to bed ○ Less than once a day
Who brushes your child's teeth (select all that apply)?
☐ Child
☐ Parent
☐ Other: _____

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: _____
_____

How often does your child have snacks?
○ No snacks ○ One time daily ○ Two times daily ○ Three or more times daily
Please list three of your child's favorite between-meal snacks: _____
_____

How often does your child drink beverages other than milk or water?
○ One time daily ○ Two times daily ○ Three or more times daily ○ Almost never/none
Please list your child's favorite beverage: _____

How important is it TO YOU for your child's teeth to be healthy?
○ Very important ○ Somewhat important ○ Not important ○ I don't know if it is important
How old was your child when the first baby tooth came in?
○ Less than 6 months old ○ 6-12 months old ○ Older than 12 months ○ I cannot exactly remember

Does your child nurse or drink from a bottle? ☐ Yes ☐ No
_____
Does your child use a sippy cup? ☐ Yes ☐ No
Does/did your child use a pacifier or suck a thumb or finger? ☐ Yes ☐ No
_____

Has your child worn orthodontic braces or orthodontic appliances? ☐ Yes ☐ No
_____

Thank you for sharing this information!
It will help our providers deliver excellent care during your child's visits.