

Ponte Vedra Pediatric Dentistry & Orthodontics

Child's Medical & Dental History

Patient Name: _____ Nickname: _____ Date of Birth: _____ Date: _____

What are the child's interests and hobbies? _____

Are you permitted by law (by right as a natural parent, legal adoption, or court order) to provide consent for dental treatment of this child?
 Yes No

What is your main dental concern today? _____

Previous dentist's name: _____ Phone: _____ City: _____

Date of last dental visit at prior dentist: _____ Date of last dental x-rays: _____

Primary Care Physician's Name: _____ Date of Last Physical Exam: _____ Phone: _____

Does this child require premedication before dental treatment? Yes No If yes, please explain _____

Does this child have any allergies? Yes No If yes, please explain _____

Is this child allergic to any meds? _____

Has this child ever been hospitalized? Yes No If yes, which medication & reaction? _____

Is this child currently under the care of a physician due to a specific condition? If yes, condition: _____

Specialist's Name: _____ Specialty: _____ Phone: _____ Last Exam Date: _____

Is the child taking any medications now? Yes No

Please list any medications/vitamins/supplements the child is currently taking or prescribed for as-needed use (continue on back if needed).

<u>List Medications:</u>	<u>Treatment for:</u>	<u>Date Started:</u>

Does this child have or has this child ever had any of the following conditions?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> ADHD/Hyperactivity | <input type="checkbox"/> Chronic Cough >3 weeks | <input type="checkbox"/> Heart condition/murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Delayed Speech Development | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Developmentally Delay | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Special Healthcare Needs |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Latex sensitivity | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy (teen) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Premature/Low Birth Weight | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hearing Loss/Impairment | <input type="checkbox"/> Psychiatric/Emotional Disorder | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> Other: _____ | | |

Please check if YES

If any of the previous questions are marked, please explain: _____

Printed Name: _____ Relationship to child: _____ Signature: _____

Doctor's Signature: _____ Today's Date: _____