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Pediatric Medical History

Child's Full Name: _____ Nickname: _____ Date of birth: ____ / ____ / ____
 Gender: M F Race/Ethnicity: _____ Height: _____ Weight: _____ Date of last physical examination: _____
 Name/address/phone of primary physician: _____
 Name/address/phone of medical specialists: _____

Is your child being treated by a physician at this time? Reason _____ YES NO
 Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? YES NO
 List name, dose, frequency & date started: _____
 Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? YES NO
 List date & describe: _____
 Has your child ever had a reaction to or problem with an anesthetic? Describe _____ YES NO
 Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____ YES NO
 Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____ YES NO
 Is your child up to date on immunizations against childhood diseases? YES NO

Please mark YES if your child has a history of the following conditions. For "Yes", provide details in the box at the bottom of this list. Mark no after each line if none of those conditions applies to you child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions YES NO
 Problems with physical growth or development YES NO
 Sinusitis, chronic adenoid/tonsil infections YES NO
 Sleep apnea/snoring, mouth breathing, or excessive gagging YES NO
 Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease YES NO
 Irregular heart beat or high blood pressure YES NO
 Asthma, reactive airway disease, wheezing, or breathing problems YES NO
 Cystic fibrosis YES NO
 Frequent colds or coughs, or pneumonia YES NO
 Frequent exposure to tobacco smoke YES NO
 Jaundice, hepatitis, or liver problems YES NO
 Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems YES NO
 Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions YES NO
 Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder YES NO
 Bladder or kidney problems YES NO
 Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems YES NO
 Rash/hives, eczema or skin problems YES NO
 Impaired vision, hearing, or speech YES NO
 Developmental disorders, learning problems/delays, or intellectual disability YES NO
 Cerebral palsy, brain injury, epilepsy, or convulsions/seizures YES NO
 Autism/autism spectrum disorder YES NO
 Recurrent or frequent headaches/migraines, fainting, or dizziness YES NO
 Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) YES NO
 Attention deficit/hyperactivity disorder (ADD/ADHD) YES NO

- Behavioral, emotional, communication, or psychiatric problems/treatment YES NO
- Abuse (physical, psychological, emotional, or sexual) or neglect YES NO
- Diabetes, hyperglycemia, or hypoglycemia YES NO
- Precocious puberty or hormonal problems YES NO
- Thyroid or pituitary problems YES NO
- Anemia, sickle cell disease/trait, or blood disorder YES NO
- Hemophilia, bruising easily, or excessive bleeding YES NO
- Transfusions or receiving blood products YES NO
- Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant YES NO
- Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS YES NO

PROVIDE DETAILS HERE:

Is there any other significant medical history **pertaining to this child or his/her family** that the dentist should be told? YES NO

If YES, describe _____

What is your primary concern about your child's oral health? _____

How would you describe:

- your child's oral health? Excellent Good Fair Poor
- your oral health? Excellent Good Fair Poor
- the oral health of your other children? Excellent Good Fair Poor Not applicable

Is there a family history of cavities? YES NO If yes, indicate all that apply: Mother Father Brother Sister

Does your child have a history of any of the following? For each YES response, please describe:

- Inherited dental characteristics YES NO
- Mouth sores or fever blisters YES NO _____
- Bad breath YES NO _____
- Bleeding gums YES NO _____
- Cavities/decayed teeth YES NO _____
- Toothache YES NO _____
- Injury to teeth, mouth or jaws YES NO _____
- Clinching/grinding his/her teeth YES NO _____
- Jaw joint problems (popping, etc.) YES NO _____
- Excessive gagging YES NO _____
- Sucking habit after one year of age YES NO If yes, which: Finger Thumb Pacifier Other
 For how long? _____

How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? YES NO

How often does your child floss his/her teeth? Never Occasionally Daily

Does someone help your child floss? YES NO

What type of toothbrush does your child use? Hard Medium Soft Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? City/community supply Private well Bottled water

Do you use a water filter at home? YES NO If YES, type of filtering system: _____

Please check all sources of fluoride your child receives:

- Drinking water Toothpaste Over-the-counter rinse Prescription rinse/gel Prescription drops/tablets/vitamins
 Fluoride treatment in the dental office Fluoride varnish by pediatrician/other practitioner Other: _____

Does your child regularly eat 3 meals each day? YES NO

Is your child on a special or restricted diet? YES NO If YES, describe: _____

Is your child a 'picky eater'? YES NO If YES, describe: _____

Does your child have a diet high in sugars or starches? YES NO If YES, describe: _____

Do you have any concerns regarding your child's weight? YES NO If YES, describe: _____

How frequently does your child have the following?

Candy or other sweets Rarely 1-2 times/day 3 or more times/day Product _____

Chewing gum Rarely 1-2 times/day 3 or more times/day Type _____

Snacks between meals Rarely 1-2 times/day 3 or more times/day Usual snack _____

Soft drinks* Rarely 1-2 times/day 3 or more times/day Product _____

(* such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities? YES NO If YES, list: _____

Does your child wear a mouthguard during these activities? YES NO If YES, type: _____

Has your child been examined or treated by another dentist? YES NO

If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? YES NO Date of most recent dental x-rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? YES NO If YES, when? _____

Has your child ever had a difficult dental appointment? YES NO If YES, describe: _____

How do you expect your child will respond to dental treatment? Very well Fairly well Somewhat poorly Very poorly

Is there anything else we should know before treating your child? YES NO

If yes, describe: _____

Signature of parent/guardian

Relationship to child

Date

Signature of staff member reviewing history

Thank you for taking the time to inform us of your child's health history