Chompers
pediatric & teen dentistry
Grow Up Smiling.

PEDIATRIC MEDICAL HISTORY

Patient's Name: _____ DOB:_____

MEDICAL HOME

Who is your child's primary care physician? _____
Doctor's Phone #: _____ Doctor's Practice Location (city/state): _____
Is your child under the care of the primary care physician for a specific condition? YES NO
If yes, what condition? _____
Is your child under the care of a pediatric specialist for a medical, emotional, or behavioral condition? YES NO
If yes, please explain: _____

HOSPITALIZATIONS AND SURGERIES

Was your child born at full term? YES NO If no, at how many weeks gestation? _____
Did your child spend time in the Neonatal Intensive Care Unit after birth? YES NO
If yes, how long? _____
Has your child ever had surgery? YES NO If yes, explain (reason for surgery, date, outcome):
_____
Has your child ever been hospitalized for a medical condition or because of significant injuries? YES NO
If yes, explain (reason, date, outcome):
_____
Has your child ever spent time in the Pediatric Intensive Care Unit? YES NO
If yes, explain (reason, date, outcome):
_____

MEDICATIONS

Is your child presently taking any medications prescribed by a doctor? YES NO
If yes, please list with dosage:
_____
_____
Is your child presently taking any over the counter medications, vitamins and/or mineral/herbal supplements? YES NO
If yes, please list:
_____
_____

ALLERGIES AND ADVERSE REACTIONS

Has your child had a bad reaction to any of the following? (Please circle all that apply)

Local anesthetics	Penicillin or other antibiotics	Sedative medications		Sulfa drugs
Codeine or other narcotics	Hay fever/seasonal allergies	Latex	Foods	Metals

Other: _____
Explain yes responses and describe type of reaction:
_____

DISEASES OR CONDITIONS *Does your child have or has had any of the following diseases or conditions?*

(Explain yes responses in the space provided)

Complications during pregnancy or birth?	YES	NO	_____
Any birth defects or inherited conditions?	YES	NO	_____
Any blood or bleeding problems?	YES	NO	_____
Any ears, eyes, nose or throat problems?	YES	NO	_____
Any heart problems?	YES	NO	_____
Any lung or breathing problems?	YES	NO	_____
Any nutritional or digestive problems?	YES	NO	_____
Any problems in the genitourinary system?	YES	NO	_____
Any problems with the brain/nervous system?	YES	NO	_____
Any developmental conditions?	YES	NO	_____
Any mental or behavioral conditions?	YES	NO	_____
Any hormone problems?	YES	NO	_____
Any bone or muscle problems?	YES	NO	_____
Any skin problems?	YES	NO	_____

Other: _____

DENTAL HISTORY

Is today your child's first dental visit? YES NO

If no, how long since your child's last dental exam? _____

If no, has your child had dental x-rays taken in the past? YES NO If yes, when? _____

If your child has seen another dentist, please provide the name of the doctor or office:

_____

Has your child ever had an unpleasant dental experience?

_____

DENTAL HEALTH STATUS

How is your child's dental health? EXCELLENT AVERAGE POOR

Does your child have dental pain at the present time?	YES	NO
Has your child sought dental care on an emergency basis?	YES	NO
Has your child injured his/her teeth, mouth, or head?	YES	NO

Does your child have or do any of the following? (Please circle all that apply)

Thumb or finger sucking	Mouth breathing	Nail biting	Lip sucking
Breastfeeding	Use a baby bottle	Use a pacifier	Bad breath
Tongue thrusting	Teeth grinding	Drooling	Cold sores
Canker sores	Other: _____		

How would you describe your child's temperament? Easy Difficult Slow to Warm Up

I certify that the above information is true and correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in the information I have provided.

Parent or Guardian Signature _____ Date _____