Child’s Medical History

Sunny Smiles Pediatric and Family Dentistry

Child’s name: ____

Physician’s name: ______________________ Physician’s Phone #:______________

Does your child have or has ever had any of the following conditions? Please explain below.

YES	*NO*	
___	___	***ADD/ADHD***
___	___	***Allergies***
___	___	***Anemia***
___	___	***Artificial joints***
___	___	***Asthma***
___	___	***Autism spectrum disorder***
___	___	***Bleeding disorder/hemophilia***
___	___	***Cancer/leukemia/tumors***
___	___	***Cerebral palsy***
___	___	***Cleft lip/cleft palate***
___	___	***Developmental delay***
___	___	***Diabetes***
___	___	***Eating disorder***
___	___	***Endocrine/Thyroid disorder***
___	___	***Emotional problems***
___	___	***Epilepsy***
___	___	***Gastrointestinal problems***

Does your child have or has ever had any of the following conditions? Please explain below.

YES	**NO**	
___	___	Hearing, speech, vision problem
___	___	Heart defect, disease, murmur
___	___	Hepatitis/Liver problems
___	___	High blood pressure
___	___	HIV/AIDS
___	___	Hydrocephalus
___	___	Kidney disorder
___	___	Latex allergy
___	___	Lung disease
___	___	Reaction/allergy to medication
___	___	Rheumatic fever
___	___	Scarlet fever
___	___	Sensory disorder
___	___	Sickle cell disease/trait
___	___	Tuberculosis
___	___	Under care of physician

Please explain any allergies or medical conditions: ________________________________

____

Please explain any hospital stays or operations: ___________________________________

____

Please list any medications with dosages: ____

____

Child's Dental Health History

Sunny Smiles Pediatric and Family Dentistry

Child's Name: ____

YES NO

___ ___ ***Has your child ever been to the dentist? If so when and where?*** __________
____

___ ___ ***Does your child brush his/her teeth daily?*** ______________________________

___ ___ ***Did you nurse your child? If so until what age?*** _________________________

___ ___ ***Has your child use a bottle? If so until what age?*** ______________________

___ ___ ***Do you use tap water for drinking and cooking?*** _________________________

___ ___ ***Does your child take fluoride supplements? If so list dosage***______________

___ ___ ***Does your child suck his/her thumb, fingers, pacifier?*** ___________________

___ ___ ***Has your child ever had trauma to his/her teeth?*** ________________________

___ ___ ***Does your child grind his/her teeth?*** ___________________________________

___ ___ ***Is your child a mouth breather?*** _______________________________________

___ ___ ***Does your child snore?*** ____

___ ___ ***Does your child have sleep apnea?*** _____________________________________

___ ___ ***History of ear infections? How often and at what age?*** __________________

___ ___ ***Has your child ever had a bad experience at a dental visit? Please explain***
____

___ ___ ***Is your child nervous about today's visit?*** ______________________________

Certification

I certify that I have read and understand the statements above. The information I have provided is correct to the best of my knowledge. This information will be held in the strictest of confidence. I understand that it is my responsibility to inform this office of any changes to my child's medical/dental health status.

Signature of Parent/Guardian: ____

Date: ________________________________

OFFICE USE ONLY:

I have reviewed the medical and dental information provided above: _____________Initials

Date: _________________

Comments:____
____
____