Pediatric Dentistry
OF PROSPECT

502.292.1160 • 12927 W. Highway 42 • Prospect, KY 40059

MEDICAL / DENTAL HISTORY

Child's Name:_____ **Date of Birth:**_____

☐ Yes ☐ No Is your child in good health? Date of last physical examination:_____

☐ Yes ☐ No Is your under the care of a physician? Reason:_____

☐ Yes ☐ No Is your child taking any medications?

Please give medication and reason:_____

☐ Yes ☐ No Is your child allergic to anything (medication, milk, grass, latex, etc.)?_____

_____

☐ Yes ☐ No Has your child had surgery/hospitalizations?

Please give reason and date:_____

☐ Yes ☐ No Are your child's immunizations up to date?

Please check if your child has or has had any of the following:

☐ ADHD/ ADD	☐ Cerebral palsy	☐ Frequent infections	☐ Rheumatic fever
☐ Anemia	☐ Cleft lip/palate	☐ Heart disease/murmur	☐ Seizures/Epilepsy
☐ Asthma	☐ Congenital birth defects	☐ Hepatitis	☐ Speech/hearing
☐ Autism	☐ Developmental delays	☐ HIV/AIDS	☐ Spina Bifida
☐ Bleeding/transfusions	☐ Diabetes	☐ Kidney Disease	☐ Syndromes
☐ Blood dyscrasias	☐ Emotional Disorder	☐ Liver/GI disease	☐ Other
☐ Cancer/tumors	☐ Fainting	☐ Recurrent headaches	

Please explain on any items checked above:_____

_____

☐ Yes ☐ No Has your child ever been to the dentist?

Name of dentist:_____ Date of last visit / x-rays:_____

☐ Yes ☐ No Has your child had any unfavorable dental experiences?

Explain:_____

☐ Yes ☐ No Has your child ever had injury to his/her face or mouth?

Describe:_____

☐ Yes ☐ No Does your child have any habits (finger/thumb, pacifier, tongue thrust, teeth grinding, mouth breathing, biting nails, other)?_____

Was your child ☐ breast fed ☐ bottle fed At what age was it stopped?_____

☐ Yes ☐ No Does your child use a "sippy" cup?

☐ Yes ☐ No Does your child eat frequent snacks between meals?

☐ Yes ☐ No Does your child drink milk/soda/juice between meals?

☐ Yes ☐ No Do you expect your child to cooperate for the exam?

☐ Yes ☐ No Does your child use a fluoridated toothpaste?

☐ Yes ☐ No Do you give your child any form of fluoride? What?_____

Do you know the source of your water: ☐ public/city ☐ well/cistern

☐ Yes ☐ No Do you filter your drinking water?

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Gum Infections	☐ Orthodontics	☐ Toothache	☐ Other
☐ Color of Teeth	☐ Jaw Sounds	☐ Teeth Sensitivity	☐ Trauma	

Comments:_____

_____

Parent's/Guardian's Signature:_____ Date:_____