FOR OFFICE USE ONLY

PEDIATRIC ORAL AND SYSTEMIC HEALTH HISTORY

While dentistry is our primary purpose, we believe children want a healthy mouth and a healthy body. Let us partner with them for both.

Name _____ Date of Birth_____ Today's Date_____

Legal Guardian Name_____ Signature_____

What is your most important concern today?

Medical Care:

Does your child:

Have special health care needs?..... Y N

Have any active medical conditions or disabilities? ... Y N

Have a history of complications during pregnancy or infancy? ..... Y N

Avoid any recommended preventive services, including vaccinations? ..... Y N

Have health goals you are trying to help him/her achieve? ..... Y N

Who is your child's primary physician?

Do you wish your child was better cared for or that you were more trusting of your child's medical team? .. Y N

Pharmacology:

List all medications your child is currently taking including prescription and OTC meds, vitamins and supplements:

Does your child have a history of antibiotic therapy for recurring infection(s)? ..... Y N

Allergies and/or Food Sensitivities:

Are you aware of any allergies?..... Y N

If so, to what?

Does your child:

Have identified food sensitivities such as dairy, wheat, soy, or nuts? ..... Y N

Eat foods that cause him/her to feel sluggish, hyperactive, or sick? ..... Y N

Suffer from GI disturbances such as discomfort, bloating, constipation, or diarrhea?..... Y N

Have acid reflux or regurgitation? ..... Y N

Have red, patchy or itchy skin or itchy ears? ..... Y N

Get congested frequently? ..... Y N

Exhibit an unhealthy weight (overweight or underweight)? ..... Y N

Exercise and Lifestyle:

Does your child:

Get less-than-daily physical exercise? ..... Y N

Have more "screen time" than physical play time?.... Y N

Regularly consume processed foods or fast foods?..... Y N

Lack interest in exercise or athletics? ..... Y N

Have concentration problems when not stimulated by electronics?? ..... Y N

Behavior:

Does your child:

Have difficulties with communication?..... Y N

Have ongoing behavior challenges at home or in school? ..... Y N

Have a diagnosis on the Autism spectrum?..... Y N

Dental History:

Does your child have a history of fear, anxiety, or avoidance behavior at a medical/dental appointment? .....Y N

Previous Dentist:

Most recent dental visit:

Most recent x-rays:

Has your child seen an orthodontist? .....Y N

Caries Disease (Tooth Decay):

Does your child:

Have primary care-givers with a history of adult decay? .....Y N

Snack more than twice a day between meals?.....Y N

Snack or drink anything other than water within an hour of bedtime? .....Y N

Sleep with a bottle? .....Y N

Consume sugary drinks including juice, soda, and/or sports drinks? .....Y N

Consume sugary foods such as crackers, breakfast cereals, chewy fruit snacks or candy?.....Y N

Have a history of tooth decay or an abscessed tooth?..Y N

Fluoride:

Does your child:

Consume water from:

- ☐ Tap (city) water
- ☐ Filtered tap water
- ☐ Well (country) water
- ☐ Bottled water

If not tap water, do you know the fluoride content of the water they drink? ..... Y N

Take fluoride supplements? ..... Y N

Receive professionally applied topical fluoride? ..... Y N

Use toothpaste with fluoride? ..... Y N

Home Care:

Does your child:

Receive daily adult-assisted tooth brushing? ..... Y N

Have skills to brush independently? ..... Y N

Receive daily adult-assisted flossing? ..... Y N

Have skills to floss independently? ..... Y N

Have professionally applied sealants? ..... Y N

Sleep and Airway:

Does your child:

Snore or make breathing noises when sleeping? ..... Y N

Have any history of strep throat, ear infections, or sinusitis? ..... Y N

Breathe with his/her mouth open? ..... Y N

Experience bedwetting? ..... Y N

Grind his/her teeth during sleep? ..... Y N

Have ADHD-history, behavior disturbances or anxiety attacks? ..... Y N

Experience any learning difficulties? ..... Y N

Have oral habits such as finger, thumb or pacifier sucking? ..... Y N

Have any "screen time" just before bed? ..... Y N

Dental and Facial Growth and Development:

Does your child:

Breathe through his/her mouth rather than nose? ..... Y N

Have any oral habits such as fingers, thumb or pacifiers? ..... Y N

Have a history of receiving breast milk or formula from a bottle rather than breast? ..... Y N

Have a history of difficulty with latching? ..... Y N

Have a tongue-tie or a lip-tie? ..... Y N

Prefer a soft diet over harder-to-chew foods? ..... Y N

Have any issues with speech or articulation of sounds such as "L" or "S"? ..... Y N

Function/Bite/TMJ Dysfunction:

Does your child:

Have difficulty with tooth eruption? ..... Y N

Have foods that are difficult to chew? ..... Y N

Choke or gag on foods not chewed well? ..... Y N

Have extra, missing or fused teeth? ..... Y N

Have clicking, popping or pain in either jaw joint? .... Y N

Aesthetics:

Are there any cranial, facial, or dental abnormalities that concern you? ..... Y N

Are there any tooth discolorations that concern you? .. Y N

Are there any tooth size or tooth position discrepancies that concern you? ..... Y N

Tooth Eruption:

Child's age (in months) when first tooth erupted? _____

Has your child experienced teething or eruption problems? ..... Y N

Injury Prevention and Trauma:

Are there areas in your home that are not considered child proof? ..... Y N

Has your child had an oral/facial injury? ..... Y N

Is there anything else you would like us to know?