



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

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

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

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

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

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:

Consumer 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 tooth paste 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
- Breath 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?