West Bend Dental Center

PEDIATRIC DEPARTMENT

_____ M F
CHILD'S NAME

_____
NAME PREFERED AGE DATE OF BIRTH

_____
WEIGHT HEIGHT

DENTAL HISTORY

HOW OFTEN DOES YOUR CHILD BRUSH?

_____

IS TOOTHBRUSHING SUPERVISED? Y N

BY WHOM? _____

IS DENTAL FLOSS USED? Y N

DOES YOUR CHILD RECEIVE:

❍ Fluoride in vitamins ❍ Fluoride in tablets/drops ❍ Fluoridated water

❍ Bottled water ❍ Well water

CHILD'S FIRST DENTAL VISIT? Y N

_____
PREVIOUS DENTIST CITY

_____
DATE OF LAST VISIT

_____
DATE OF LAST DENTAL X-RAYS

ANY INJURIES TO CHILD'S TEETH OR JAWS?

Y N WHEN? _____

ANY RECENT DENTAL PAIN?

_____

_____

HISTORY OF:

BREAST FEEDING _____
BOTTLE HABITS _____
THUMB/FINGER SUCKING _____
PACIFIER _____
DENTAL GRINDING/CLENCHING _____
PAIN IN JAW JOINTS _____

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL/DENTAL CARE?

Y N (IF YES, PLEASE EXPLAIN)

_____

_____

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST? _____

MEDICAL HISTORY

DOES YOUR CHILD HAVE A HISTORY OF HEALTH PROBLEMS? Y N

IF YES, PLEASE EXPLAIN _____

_____

_____

PHYSICIAN/PEDIATRICIAN'S NAME _____

ADDRESS _____

PHONE NO. _____

DATE OF LAST PHYSICAL EXAM_____

IS YOUR CHILD PRESENTLY UNDER THE CARE OF A SPECIALIST FOR ANY MEDICAL REASON? Y N

IF YES, FOR WHAT? _____

_____

SPECIALIST'S NAME _____

PHONE NO. _____

ARE ANTIBIOTICS NEEDED FOR DENTAL WORK DUE TO HEART MURMUR, HEART DEFECT, PROSTHESIS, SHUNT OR OTHER REASON? Y N

IS YOUR CHILD PRESENTLY TAKING ANY MEDICATIONS? Y N

WHAT? _____

IS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? Y N

FOR WHAT? _____

IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? Y N

PLEASE LIST _____

IS YOUR CHILD ALLERGIC TO ANY DYES OR FOODS? Y N

PLEASE LIST _____

IS YOUR CHILD ALLERGIC TO ANY ENVIRONMENTAL POLLUTANTS? Y N

IS YOUR CHILD ALLERGIC TO METALS (SNAPS)? Y N

IS YOUR CHILD ALLERGIC TO LATEX? Y N

HAS YOUR CHILD OR ANY MEMBER OF YOUR FAMILY HAD A PROBLEM WITH A GENERAL ANESTHETIC? Y N

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Y N ADD/ADHD
Y N AIDS/HIV
Y N Anemia
Y N Asthma (IF YES, WHAT TRIGGERS IT?)
_____
Y N Autism Spectrum Disorder
Y N Autism
Y N Bladder Conditions
Y N Blood Disease
Y N Blood Transfusions
Y N Birth Defects
Y N Bone/Joint Problems
Y N Brain Injury
Y N Bruising Easily
Y N Cancer _____
_____
Y N Cerebral Palsy
Y N Child Abuse
Y N Chronic Adenoid/Tonsil Infection
Y N Chronic Ear Infections
Y N Cleft Lip/Palate
Y N Convulsion/Seizures
Y N Developmentally Delayed
Y N Diabetes
Y N Emotional Disturbance
Y N Epilepsy
Y N Eye Problem
Y N Excessive Bleeding Problem
Y N Excessive Gagging
Y N Fainting or Dizziness
Y N Growth/Developmental Problems
Y N Heart Surgery
Y N Heart Murmur/Defect
Y N Headaches
Y N Hearing/Speech Impediments
Y N Hemophilia
Y N Hepatitis/Liver Disease
Y N High Blood Pressure
Y N Kidney Disease
Y N Mental Disability
Y N Mouth Sores
Y N Nutritional Deficiency
Y N Premature Birth _____
Y N Psychiatric Care
Y N Rheumatic Fever
Y N Scoliosis
Y N Sickle Cell Anemia
Y N Syndrome _____
Y N Tuberculosis
Y N Other_____
_____
Y N Do you wish to talk to the doctor privately about a special concern?