PEDIATRIC HEALTH QUESTIONNAIRE

NAME:______________________________ **BIRTH DATE**: ______________________________

DIRECTIONS TO THE PARENT / GUARDIAN: The following information about your child's health history is very important for us to provide the best possible dental care in a safe way. Incorrect information may be dangerous to your child's health. ALL questions must be answered completely and accurately. If you don't understand a question, or are unsure of the answer, or want to discuss it with the dentist, circle its number or line. This health history questionnaire will become a part of the patient's dental treatment record and will be considered confidential information.

MEDICAL HISTORY

Name of your child's Physician ____________________Office Phone______________________________
Address of your child's Physician____

1. Is your child in good health?.......................... Yes No Don't Know
2. Does your child have a health problem? .... Yes No Don't Know
If yes, explain____
3. Has your child ever been hospitalized?.......................... Yes No Don't Know
If yes, explain____
4. Has your child had an operation under general anesthesia? .... Yes No Don't Know
If yes, explain____
5. Date of your child's last visit to your doctor?__________Reason for visit______________________________
____
6. Is your child currently receiving treatment or regular medical care by a doctor? .... Yes No Don't Know
If yes, for what condition(s)?____
7. List medications your child has taken in the past____
____
8. List all daily medications your child currently takes____
____
9. Is your child allergic to any medications?.......................... Yes No Don't Know
If yes, what medications and reactions?____
____
10. Were there any problems at birth?____________________Weight at birth______________________________
11. Has your child ever had or been treated by a doctor for:

a. heart disease.......................... Yes No Don't Know
b. rheumatic fever .... Yes No Don't Know
c. anemia.......................... Yes No Don't Know
d. bleeding/hemophilia.......................... Yes No Don't Know
e. blood transfusion.......................... Yes No Don't Know
f. hepatitis .... Yes No Don't Know
g. AIDS, AIDS related complex, or HIV positive .... Yes No Don't Know
h. liver disease .... Yes No Don't Know
i. kidney disease.......................... Yes No Don't Know
j. diabetes.......................... Yes No Don't Know
k. cancer.......................... Yes No Don't Know
l. arthritis.......................... Yes No Don't Know
m. seizures .... Yes No Don't Know
n. asthma.......................... Yes No Don't Know
o. tonsil or adenoid problems.......................... Yes No Don't Know
p. sleep problems .... Yes No Don't Know
q. cleft lip / cleft palate .... Yes No Don't Know
r. speech / hearing problems .... Yes No Don't Know
s. eye problems .... Yes No Don't Know
t. skin problems.......................... Yes No Don't Know

If yes to any of the above, please explain____
____
____

12. Has your child experienced recent rapid growth? .... Yes No Don't Know
13. If female, has your child reached menarche (first monthly period) .... Yes No Don't Know
14. Do you consider your child to be (check one):
_______advanced in learning process _______________progressing normally _______________slow learner
15. What grade is your child in?__________School child attends______________________________
16. Are there any other problems about your child's health that you know of? .... Yes No Don't Know
If yes, please explain____
____

DENTAL HISTORY

17. What is your major dental concern about your child?______________________________________
____
18. Date of your child's last visit to a dentist?______________Last dental x-rays taken?______________________
19. Reason for your child's last visit or series of visits?____________________________________
20. Has your child ever experienced an unusual reaction to dental medication or anesthetic? .... Yes No Don't Know
If yes, explain____
21. Has your child experience prolonged bleeding following dental treatment? .... Yes No Don't Know
If yes, explain____
22. Has your child had any other complications following dental treatment? .... Yes No Don't Know
If yes, explain____
23. Has your child had any injury to the teeth, jaws, or face? .... Yes No Don't Know
If yes, explain____
24. Are you happy with the appearance of your child's teeth? .... Yes No Don't Know
If no, explain____
25. Do your child's gums bleed with brushing? .... Yes No Don't Know
26. Are any of your child's teeth sensitive to hot, cold or eating? .... Yes No Don't Know
27. Does your child complain of toothache? .... Yes No Don't Know
If yes, explain____
28. Does your child experience pain or clicking in the jaw joints? .... Yes No Don't Know
29. Are there any sores or growths in your child's mouth? .... Yes No Don't Know
30. Was your child breast fed .... Yes No Don't Know
If yes, at what age was it stopped?____
31. Was your child bottle fed? .... Yes No Don't Know
If yes, at what age was it stopped?____
32. Has your child ever sucked fingers, thumbs or a pacifier? .... Yes No Don't Know
If yes, at what age was it stopped?____
33. Is there fluoride in your drinking water? .... Yes No Don't Know
34. Are your child's teeth brushed at least once a day? .... Yes No Don't Know
35. Do you use a toothpaste that contains fluoride? .... Yes No Don't Know
36. Do you give your child any other form of fluoride? .... Yes No Don't Know
37. Does your child participate in a school fluoride swish program? .... Yes No Don't Know
38. Has your child inherited any family dental characteristics? .... Yes No Don't Know
39. Do you think your child will cooperate for dental treatment? .... Yes No Don't Know
40. Do you have any other dental concerns or complaints? .... Yes No Don't Know
If yes, explain____
____
____

SIGNATURE OF PARENT / GUARDIAN: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my child's medical or dental status to the dentist at the earliest possible time and I agree to do so. I give permission to the dentist to obtain any additional information regarding my child's medical history needed to provide my child the best dental treatment possible.

PERSON COMPLETING THIS FORM: Signature____Date___________
Relationship to the Patient:____