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 _____

Relationship to Patient _____ Office Witness _____

What is your primary concern today? _____

Medical Care:

Does your child:

Have special health-care needs? ..... Y N
If yes: _____
_____

Have any active medical conditions or disabilities? Y N
If yes: _____
_____

Have a history of complications during pregnancy or infancy? ..... Y N
Was your child delivered by cesarean section? ..... Y N
Avoid any recommended preventive services, including vaccinations? ..... Y N
Have health goals you are trying to help them achieve? ..... Y N
Has your child had removal of tonsils? ..... Y N
Has your child had removal of adenoids? ..... Y N
Has your child had other surgeries? ..... Y N
If so, please list: _____
_____

Have a diagnosis on the Autism spectrum? ..... Y N
Have ongoing behavior challenges at home or in school? ..... Y N

Pharmacology:

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

Please list all medications your child is currently taking, Including prescription, OTC meds, vitamins, supplements:

_____
_____
_____
_____
_____

Exercise and Lifestyle:

Does your child:

Get less-than-daily physical exercise? ..... Y N
Regularly consume processed foods or fast foods? ..... Y N
How many hours of screen time does your child have per day (TV, phone, computer, tablet, gaming)? _____
What type? _____

Allergies and/or Food Sensitivities:

Are you aware of any allergies? ..... Y N
If so, please list: _____
_____

Does your child:

Have identified food sensitivities such as dairy, wheat, soy, gluten, or nuts? ..... Y N
Eat foods that cause them 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 skin or itchy ears? ..... Y N
Get congested frequently? ..... Y N
Exhibit an unhealthy weight (overweight or underweight)? 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
Take fluoride supplements? ..... Y N
Use toothpaste with fluoride? ..... Y N
What kind of water does your child drink? _____
How much plain water does your child drink/day? _____

Dental History:

Does your child have a history of fear, anxiety, or avoidance behavior at medical/dental visits? ..... Y N
Has your child been evaluated for orthodontic treatment? ..... Y N
Most recent dental visit? _____
Most recent x-rays? _____

Caries Disease (Tooth Decay):

Does your child:

Have primary care-givers with a history of adult decay? ..... Y N
Snack more than twice per day? ..... Y N
Snack or drink anything other than water within an hour of bedtime? ..... Y N
Sleep with a bottle? ..... Y N
Have a history of tooth decay or abscessed tooth? 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
What are your child's typical snacks?

_____
_____

Function/Bite/TMJ Dysfunction:

Does your child:

Have difficulty with tooth eruption? ..... Y N
Have difficulty chewing particular foods?..... 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
Does your child experience headaches? ..... 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

Dental and Facial Growth and Development:

Does your child:

Breathe through their mouth rather than nose? ..... Y N
Have any oral habits such as fingers, thumb, or pacifier? .. 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 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
Has your child had an oral/facial injury? ..... Y N
Child's age (in months) when first tooth erupted? _____

Sleep and Airway:

Does your child:

Have frequent colds? ..... Y N
Snore or make breathing noises when sleeping? ..... Y N
Have any history of strep throat, ear infections, or sinusitis? ..... Y N
Breathe with their mouth open? ..... Y N
Experience bedwetting? ..... Y N
Grind their teeth? ..... Y N
Have ADHD-history, behavior disturbances, or anxiety attacks? ..... Y N
Experience any learning difficulties? ..... Y N

Is there anything else you would like us to know?

_____
_____
_____
_____
_____
_____
_____
_____