

Dental Health Questions (age 0-7)

A child's dental health is affected by many different things. To help us better evaluate your child's dental health, please answer the following questions.

Child's Name: _____

Home Dental Care

- How often does your child brush? _____
- Does your child use a manual toothbrush or electric toothbrush? _____
- Is toothbrushing supervised? Yes No
- What kind of toothpaste is used? _____
- Do you floss your child's teeth? Yes No
- Does your child drink well water, bottled water, or city water? _____
- Do you have a water filter? Yes No

Dental History

- Is this your child's first dental visit? Yes No
- If no, date of Last Dental Visit: _____ Date of Last X-Rays: _____
- Any injuries to your child's teeth or jaws? Yes No
- If yes, explain? _____
- History of:

History of:	When?
Breast feeding	_____
Bottle feeding	_____
Thumb or Finger sucking	_____
Pacifier	_____
Dental grinding or clenching	_____
- Has there been any unfavorable reaction from previous medical or dental care? Yes No
- If yes, please explain: _____
- Has your child had recent dental pain? Yes No

Diet

- Was/is your child put to bed with a bottle? Yes No
- If yes, what was/is in the bottle? _____
- Was/is your child allowed to carry a bottle or cup throughout the day containing something other than plain water? Yes No
- How many meals per day does your child eat? _____
- How many snacks does your child have on an average day? _____
- Please list some favorite/frequent snacks: _____
- Please list some favorite/frequent drinks: _____

How did you hear about us?

Altoona Pediatric Dental

Health History

Patient Name _____

Gender M F

Is your child presently under the care of a physician? Yes No If yes, what for? _____

FAMILY PHYSICIAN'S NAME _____ PHONE NUMBER _____

DATE OF LAST PHYSICAL EXAM _____

Is your child presently under the care of a medical specialist? Yes No If yes, what for? _____

SPECIALIST'S NAME _____ PHONE NUMBER _____

Does your child have a history of health problems? Yes No If yes, Explain. _____

Are antibiotics required for dental work? (heart murmur, heart defect, prosthesis, shunt or other reason) Yes No

Is your child presently taking any medications? Yes No

If yes, please list _____

Has your child had a history of taking medications frequently? Yes No

Which ones? _____

Has your child ever been hospitalized or had surgery? Yes No

What For? _____

Is your child allergic to any medications? Yes No If yes, what? _____

Is your child allergic to any dyes or foods? Yes No If yes, what? _____

Is your child allergic to metals (Snaps)? Yes No

Is your child allergic to latex? Yes No

Has any member of the family, including your child, had a problem with a general anesthetic? Yes No

If yes, explain _____

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO:

Y N

AIDS - HIV

Anemia

Arthritis

Asthma, If yes, what triggers it?

Autism

Bladder Conditions

Blood Disease

Blood Transfusions

Birth Defects

Bone or Joint Problems

Brain Injury

Bruising Easily

Cancer or Malignancies

Cerebral Palsy

Chemotherapy/Radiation

Child Abuse

Chronic Adenoid/Tonsil Infection

Chronic Ear Infections

Cleft Lip/Palate

Congenital Heart Lesion

Convulsions/Seizures

Developmentally Delayed

Diabetes

Drug Addiction

Ear Stuffiness, Itching or Noises

Emotional Disturbance

Epilepsy

Eye Problem

Y N

Excessive Bleeding Problem

Excessive Gagging

Fainting or Dizziness

Fever Blisters

Growth & Development Problems

Heart Surgery

Headaches

Hearing/Speech Impairments

Heart Murmur/Defect

Hemophilia

Hepatitis or Liver Disease

High Blood Pressure

Hyperactivity/ADD

Kidney Disease

Leukemia

Mental Disability

Mitral Valve Prolapse

Mouth Sores

Orthopedic Problems

Pain in Jaw Joints

Premature Birth

Psychiatric Care

Rheumatic Fever

Scoliosis

Sickle Cell Anemia

Syndrome _____

Thyroid Problem

Tuberculosis

Other _____

Signature _____

Date _____

Relationship to Child _____

Reviewed by Doctor _____