

Altoona

Pediatric

Dental

JENIFER WOLFE DDS, PEDIATRIC DENTIST

Dental Health Questions (age 8+)

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? _____

What kind of toothpaste is used? _____

Is dental floss used? 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? _____

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

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 | Y N |
| <input type="radio"/> AIDS - HIV | <input type="radio"/> Excessive Bleeding Problem |
| <input type="radio"/> Anemia | <input type="radio"/> Excessive Gagging |
| <input type="radio"/> Arthritis | <input type="radio"/> Fainting or Dizziness |
| <input type="radio"/> Asthma, If yes, what triggers it?
_____ | <input type="radio"/> Fever Blisters |
| <input type="radio"/> Autism | <input type="radio"/> Growth & Development Problems |
| <input type="radio"/> Bladder Conditions | <input type="radio"/> Heart Surgery |
| <input type="radio"/> Blood Disease | <input type="radio"/> Headaches |
| <input type="radio"/> Blood Transfusions | <input type="radio"/> Hearing/Speech Impairments |
| <input type="radio"/> Birth Defects | <input type="radio"/> Heart Murmur/Defect |
| <input type="radio"/> Bone or Joint Problems | <input type="radio"/> Hemophilia |
| <input type="radio"/> Brain Injury | <input type="radio"/> Hepatitis or Liver Disease |
| <input type="radio"/> Bruising Easily | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Cancer or Malignancies | <input type="radio"/> Hyperactivity/ADD |
| <input type="radio"/> Cerebral Palsy | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Chemotherapy/Radiation | <input type="radio"/> Leukemia |
| <input type="radio"/> Child Abuse | <input type="radio"/> Mental Disability |
| <input type="radio"/> Chronic Adenoid/Tonsil Infection | <input type="radio"/> Mitral Valve Prolapse |
| <input type="radio"/> Chronic Ear Infections | <input type="radio"/> Mouth Sores |
| <input type="radio"/> Cleft Lip/Palate | <input type="radio"/> Orthopedic Problems |
| <input type="radio"/> Congenital Heart Lesion | <input type="radio"/> Pain in Jaw Joints |
| <input type="radio"/> Convulsions/Seizures | <input type="radio"/> Premature Birth |
| <input type="radio"/> Developmentally Delayed | <input type="radio"/> Psychiatric Care |
| <input type="radio"/> Diabetes | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Drug Addiction | <input type="radio"/> Scoliosis |
| <input type="radio"/> Ear Stuffiness, Itching or Noises | <input type="radio"/> Sickle Cell Anemia |
| <input type="radio"/> Emotional Disturbance | <input type="radio"/> Syndrome _____ |
| <input type="radio"/> Epilepsy | <input type="radio"/> Thyroid Problem |
| <input type="radio"/> Eye Problem | <input type="radio"/> Tuberculosis |
| | <input type="radio"/> Other _____ |

Signature _____

Date _____

Relationship to Child _____

Reviewed by Doctor _____