timberwood park
PEDIATRIC DENTISTRY

MEDICAL HISTORY

Your Child

First & Last Name: _____ Preferred Name: _____

Birthdate:_____ Age:_____ Sex:_____ SS#:_____

School he/she attends: _____ Grade level: _____

Child's home address:_____

City, State & Zipcode:_____

Medical History

Does your child have any major health problems? YES____ NO____

If yes, please explain_____

Has your child been hospitalized? YES____ NO____

If yes, please explain_____

Have you ever been told that you child has a heart murmur? YES____ NO____

If yes, please explain_____

Is your child currently being treated by a physician? YES____ NO____

If yes, please explain_____

What medications is your child currently taking? Are they taken in the AM or PM?

_____

_____

Does your child suffer from allergies? YES____ NO____

If yes, please explain_____

Does your child have asthma? YES____ NO____

If yes, what initiates symptoms/attacks? _____

Has your child ever experienced an unfavorable reaction to drugs, including antibiotics, or local anesthetics?

YES____ NO____ If yes, please explain_____

Does your child have developmental or behavioral problems? YES____ NO____

If yes, please explain_____

How would you classify your child's ability to learn?

Above Average____ Average ____ Below Average____ Learning Disabled____

Has your child had any history or difficulty with any of the following? (Please Circle)

ADD/ADHD	Diabetes	Malignancies/Cancer	Other_____
Asthma	Ears/Hearing	Rheumatic Fever	
Bleeding Disorder	Heart	Seizures/Epilepsy	
Cerebral Palsy	HIV +	Thyroid	
Cleft Lip/Palate	Kidneys	Tuberculosis	
Chronic Sinus	Liver/Hepatitis	Sleep Apnea/ Snoring	

Child's Physician:_____ Address: _____ Phone #:_____

In case of an emergency (friend or relative): _____ Phone #: _____

DENTAL HISTORY: Last visit to the dentist: _____ Dentist:_____

Services Rendered:_____

What was your child's behavioral response to past dental or medical care?

_____

_____

Does your child have any dental complications? YES____ NO____

If yes, please explain_____

Any injury to the teeth, mouth, or head? _____

Any history of the following? (circle) Headaches Bruxism TMJ/Joint Problems Swelling Pain

Does your child have any habits, past or current? (circle) Thumb sucking Finger sucking Pacifier Lip biting

Does your child brush daily? YES_____ NO_____

Do you assist your child with brushing? YES_____ NO_____

Do you assist your child with flossing? YES_____ NO_____

Does your child take fluoride in any form? (circle) Water Toothpaste Fluoride drops Chewable tablets Rinse

Where is your water source from? _____

What is your child's attitude towards dental care? _____

Is there any information that you would like us to know about your child or have specific concerns?

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Legal Guardian: _____ Date: _____