CROSSROADS PEDIATRIC DENTISTRY

PEDIATRIC DENTAL AND MEDICAL HISTORY

HAROLD S. MARKS D.D.S., P.A.

Child's Name and (Nickname) ____Today's Date ______________________________

Date of Birth ___________________________Age __________ Sex Male Female Is Child Adopted? Yes No From? ______________

Mother's Name ____ Father's Name ____

Best Phone Number(s) to Reach You____

Name of Dental Insurance Policy Holder ____

Parents are: Married Divorced Single Other Describe,____

Does your child have ANY condition that requires ANTIBIOTICS prior to dental treatment? Yes No

Please Answer Every Question Completely. Your Answers May Affect Your Child's Dental Care.

DENTAL HISTORY

DATE of Child's Last Visit to a Dentist ?__________________________________What Service?____

Has your Child complained of dental problems? Yes No What?____

Do you believe your Child has tooth decay? Yes No Don't Know

Has your Child had any injury to head or teeth? Yes No Describe? ____

Has your Child lost any teeth due to injury? Yes No Describe?____

Does your Child have any mouth habits such as:

Thumb Sucking Yes No — Nursing Bottle Habits Yes No

Nail Biting Yes No — Pacifier Yes No

Mouth Breathing Yes No — Speech Habits Yes No Describe ___________________________________

Has your Child had any orthodontic treatment, braces, appliances? Yes No Describe____

We Appreciate Your Taking the Time and Making the Effort to Answer These Questions.

ORAL HYGIENE

Does your Child brush teeth daily? Yes No Do YOU assist child with tooth brushing daily? Yes No Sometimes

Is dental floss used? Yes No By Whom? Child Parent Both Daily Sometimes

Is your water fluoridated Yes No , or do you HAVE or NEED a Fluoride RX? HAVE NEED

We Believe in Making Each Visit as Pleasant as Possible for You and for Your Child.

NATURE OF TODAY'S VISIT

New Patient Comprehensive Examination? Yes No or Emergency? Yes No Describe?____

What is your Child's attitude toward visiting the dentist? Positive Neutral Negative

Has your Child had any unhappy dental experiences? Yes No Where, When? ____

Describe any concerns you have about your Child's behavior at the dentist?____

Your Answers to These Questions are Very Important to Your Child's Dental Care

MEDICAL HISTORY

Child's Primary Care Physician ____

Address ____ Phone _________________________

Date of last physical examination ______________________________ Results ____

Any other Physicians? ____

Other Physician's address and phone ____

Are your Child's immunizations up to date? Yes No

Allergies/Sensitivities/Reactions:

Anesthetics, Local and/or General Yes No Describe?____

Sedative Agents Yes No Describe?____

Drugs or Medications (such as antibiotics) Yes No ____

Environmental such as pollen, dogs, cats, dust Yes No ____

Latex, Food, Dyes, Metal, Acrylic Yes No ____

Medications, including over-the-counter analgesics, vitamins and herbal supplements

What is the Child taking? ____ Dose? ____________________ Frequency____________________

Any reactions? Yes No ____

Hospitalizations and/or Surgeries

Reason (s), Date(s), Outcome(s) ____

Significant Injuries (such as to head or teeth, broken bones, severe lacerations, car accidents) Describe, date, outcome ________________________

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Has Child had ANY History with ANY of the following?

Complications during Pregnancy Yes No
Prematurity Yes No
Congenital Anomalies Yes No
Cleft Lip/Palate Yes No
Inherited Disorders Yes No
Nutritional Deficiencies Yes No
Problems of Growth or Stature Yes No
Lesions (sores) in or around the mouth Yes No
Chronic Adenoid/ Tonsil Infections Yes No
Chronic Ear Infections Yes No
Ear or Hearing Problems Yes No
Eye or Visual Problems Yes No
Sinusitis Yes No
Speech Impairments Yes No
Apnea/Snoring/Mouth-Breathing Yes No
Transfusion Yes No
Excessive Bleeding Yes No
Bruising Easily Yes No
Hemophilia Yes No
Type? ______________________________________
Sickle Cell Disease Trait Yes No
Cancer, Tumor, other Malignancy Yes No
What? _____________________________________
Immune Disorder Yes No
Chemotherapy Yes No
What? _____________________________________
Radiation Therapy Yes No
Hematopoietic cell (bone marrow)
Transplant: Yes No
Diabetes Yes No
Growth Delays Yes No
Hormonal Problems Yes No
Precocious Puberty Yes No
Thyroid Problems Yes No
Eating Disorder, Ulcer, Excessive
Gagging: Yes No
GERD [Gastro Esophageal/
Acid Reflux Disease]: Yes No
Hepatitis A B C or Variant Yes No
Liver Disease Yes No
Intestinal Problems Yes No
Prolonged Diarrhea Yes No
Unintentional Weight Loss Yes No
Lactose Intolerance Yes No
Dietary Restrictions Yes No
What? ______________________________________
Kidney Disease or Infections Yes No
Bladder Disease or Infections Yes No
Sexually Transmitted Disease(s) Yes No
Females: Pregnancy Yes No
Birth Control Pills Yes No

Asthma Yes No
Asthma Medications, Triggers, Last Attack Hospitalizations:
____
Tuberculosis Yes No
Cystic Fibrosis Yes No
Frequent colds, coughs, syncytial virus Yes No
Reactive airway disease/breathing problems:
Yes No
Smoking Yes No
Congenital Heart Defect or Disease Yes No
Heart Murmur Yes No
Rheumatic Fever or Rheumatic
Heart Disease: Yes No
Anemia Yes No
Blood Disorder Yes No
Arthritis Yes No
Scoliosis Yes No
Bone or Joint Problems Yes No
TMJ (temporomandibular joint) Problems (clicking,
popping, locking, difficulties opening) Yes No
Fever Blisters Yes No
Eczema Yes No
Rash/Hives Yes No
Skin Condition Yes No
Fainting Yes No
Dizziness Yes No
Autism Yes No
Type? _______________________________________
Developmental Disorders Yes No
What? _______________________________________
Learning Problems/Delays Yes No
What? _______________________________________
Mental Disability Yes No
Brain Injury Yes No
Cerebral Palsy Yes No
Convulsions/Seizures Yes No
Epilepsy Yes No
Type? _______________________________________
Headaches/Migraines Yes No
Mild, Moderate, Major Duration? ____________________
Hydrocephaly Yes No
Shunts Yes No
Type? _______________________________________
Measles, Mumps Rubella, Scarlet Fever,
Varicella (Chicken Pox), Mononucleosis Yes No
Cytomegalovirus (CMV), Pertusis
(Whopping cough) Yes No
Human Immunodeficiency Virus/Acquired
Immune Deficiency Syndrome (HIV/AIDS) Yes No
Is there a family history of Genetic Disorders,
problems with general anesthesia, or serious
medical problems or illnesses Yes No
Passive Smoke Exposure Yes No

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.
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____
____

May we request release of your Child's medical records? Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered completely and fully to my knowledge and satisfaction. I acknowledge that any errors or omissions that I have made in the completion of this form my affect my child's dental care, and I will do my best to correct these errors as soon as I become aware of them.

This information was discussed with and given by Mother , Father , Legal Guardian , Other ____________________________

Signature ____ Date__________________________

Thank you for completing this form.
Harold S. Marks D.D.S., M.Sc.D.
Diplomate of the American Board of Pediatric Dentistry