3 Year Medical History Update

PATIENT INFORMATION

Child's Name: _____ Preferred Name: _____ Date of Birth___/___/____
Street Address: _____City: _____State:____ Zip:_____
Home Phone:_____ School Currently Attending: _____Grade Level: ____
Child's Physician/Pediatrician: _____ Phone#: _____

PARENT INFORMATION

Parent/Legal Guardian: _____ Relation to Patient:_____
Employer:_____ Work #:_____ Mobile #:_____Date of Birth ___/___/____
Email: _____Are There Any Changes in Dental Insurance □ Yes □ No
Do you prefer to be contacted by email? □ Yes □ No

DENTAL HISTORY

□ Yes □ No Does your child suck a finger, thumb, or pacifier?
□ Yes □ No Does your child have pain with chewing, yawning, or wide opening?
□ Yes □ No Does your child snack frequently? What are their favorite snack foods? _____
□ Yes □ No Does your child drink juice or soda? If yes, how often? _____
□ Yes □ No Does your child floss their teeth?
Does your child brush on their own? □ Or with assistance? □

Please check if your child is having problems with any of the following:

□ Cavities	□ Toothache	□ Sensitive Teeth	□ Mouth Breathing
□ Trauma	□ Gum Infections	□ Color of Teeth	□ Other
□ Orthodontics	□ Jaw Sounds	□ Grinding of Teeth	

Comments: _____

FLUORIDE HISTORY

□ Yes □ No Is your home water supply fluoridated?
□ Yes □ No Does your child use a fluoride toothpaste?
□ Yes □ No Do you give your child any other forms of fluoride? What? _____

MEDICAL HISTORY

□ Yes □ No Is your child in good health? Date of last physical exam _____
□ Yes □ No Has your child ever had a health problem? _____
□ Yes □ No Is your child allergic to anything? _____
□ Yes □ No Is your child currently taking any medications? Please give medication, dose, and reason: _____
_____
□ Yes □ No Are your child's immunizations current?
□ Yes □ No Has your child had any injuries to the head or neck? If so, what? _____
□ Yes □ No Have you ever been told that your child needs to take *antibiotic before dental treatment?*
□ Yes □ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain:
_____

Do you consider your child to be: □ advanced □ progressing normally □ slow in the learning process

Please check if your child has been treated for any of the following:

□ Abuse	□ Cancer/tumors	□ Heart murmur	□ Rheumatic fever
□ ADD/ADHD	□ Cerebral palsy	□ Hepatitis	□ Seizures
□ AIDS	□ Cleft lip/palate	□ Kidney disease	□ Sickle cell disease/trait
□ Anemia	□ Congenital birth defects	□ Liver/GI disease	□ Significant injuries
□ Anxiety disorder	□ Diabetes	□ Mental delays	□ Snoring
□ Arthritis	□ Endocrine/growth	□ Personality/social disorder	□ Speech/hearing
□ Asthma/breathing	□ Eyesight	□ Physical delays	□ Spina bifida
□ Autism	□ Frequent infections	□ Recurrent headaches	□ Tonsil/adenoid problems
□ Bleeding/transfusions	□ Heart Disease	□ Recurrent herpes/fever blisters**	□ Tuberculosis
□ Blood dyscrasias			

Please note that if your child has an **active herpes lip lesion on the day of your scheduled appointment, we will ask you to reschedule.

Other: _____
If any boxes checked, please describe further:_____
_____

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Southern Village Pediatric Dentistry of any changes in my child's medical status.

Legal Guardian's Signature: _____Date:_____

Doctor Signature: ____Date:___________________