

Date

PID #

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MEDICAL ALERT Y  N

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form.

Child's Name: \_\_\_\_\_ Preferred to be called: \_\_\_\_\_  
(Last) (First)

Date of Birth: (D) \_\_\_\_\_ / (M) \_\_\_\_\_ / (Y) \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Emergency Contact Name & Number: \_\_\_\_\_

Preferred way to be contacted for appointment reminders: Please circle PHONE or EMAIL

How did you hear about us? \_\_\_\_\_

Has your child been examined or treated by another dentist? \_\_\_\_\_  YES  NO

Were x-rays taken? \_\_\_\_\_  YES  NO

Has your child ever had a difficult dental appointment? \_\_\_\_\_  YES  NO

How do you expect your child will respond to dental treatment? Very well \_\_\_\_\_ Fairly well \_\_\_\_\_ Somewhat poorly \_\_\_\_\_ Very poorly \_\_\_\_\_

Name/phone number of primary physician and/or medical specialists: \_\_\_\_\_

Is your child being treated by a physician at this time? Reason \_\_\_\_\_  YES  NO

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements \_\_\_\_\_  YES  NO

List name, dose, frequency & date started: \_\_\_\_\_

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? \_\_\_\_\_  YES  NO

List date & describe: \_\_\_\_\_

Has your child ever had a reaction to or problem with an anaesthetic? Describe: \_\_\_\_\_  YES  NO

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List: \_\_\_\_\_  YES  NO

Is your child allergic to latex or anything else such as metals, acrylic, or dye? List: \_\_\_\_\_  YES  NO

Is your child up to date on immunizations against childhood diseases? \_\_\_\_\_  YES  NO

## **MEDICAL HISTORY:**

**Please mark YES/NO if your child has a history of the following conditions. For each "YES", provide details.**

Complications at birth, prematurity, birth defects, syndromes, or inherited conditions: \_\_\_\_\_  YES  NO

Problem with physical growth or development: \_\_\_\_\_  YES  NO

Sinusitis, chronic adenoid/tonsil infections: \_\_\_\_\_  YES  NO

Sleep apnea/snoring, mouth breathing, or excessive gagging: \_\_\_\_\_  YES  NO

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic disease: \_\_\_\_\_  YES  NO

Irregular heart beat or high blood pressure: \_\_\_\_\_  YES  NO

Asthma, reactive airway disease, wheezing, or breathing problems: \_\_\_\_\_  YES  NO

Cystic fibrosis: \_\_\_\_\_  YES  NO

Frequent colds or cough, or pneumonia: \_\_\_\_\_  YES  NO

Frequent exposure to tobacco smoke: \_\_\_\_\_  YES  NO

Jaundice, hepatitis, or liver problems: \_\_\_\_\_  YES  NO

Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems: \_\_\_\_\_  YES  NO

Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions: \_\_\_\_\_  YES  NO

Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder: \_\_\_\_\_  YES  NO

Bladder or kidney problems: \_\_\_\_\_  YES  NO

Arthritis, scoliosis, limited use of arms or muscle/bone/joint problems: \_\_\_\_\_  YES  NO

Rash/hives, eczema or skin problems: \_\_\_\_\_  YES  NO

Impaired vision, hearing, or speech: \_\_\_\_\_  YES  NO

Developmental disorders, learning problems/delays, or intellectual disability: \_\_\_\_\_  YES  NO

Cerebral palsy, brain injury, epilepsy, or convulsions/seizures: \_\_\_\_\_  YES  NO

Autism/autism spectrum disorder: \_\_\_\_\_  YES  NO

Recurrent or frequent headaches/migraines, fainting, or dizziness? \_\_\_\_\_  YES  NO

Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous): \_\_\_\_\_  YES  NO

Attention deficit/hyperactivity disorder (ADD/ADHD): \_\_\_\_\_  YES  NO

Behavioural, emotional, communication, or psychiatric problems/treatment: \_\_\_\_\_  YES  NO

Abuse (physical, psychological, emotional, or sexual) or neglect: \_\_\_\_\_  YES  NO

Diabetes, hyperglycemia, or hypoglycemia: \_\_\_\_\_  YES  NO

Precocious puberty or hormonal problems: \_\_\_\_\_  YES  NO

Thyroid or pituitary problems: \_\_\_\_\_  YES  NO

Anemia, sickle cell disease/trait, or blood disorder: \_\_\_\_\_  YES  NO

Hemophilia, bruising easily, or excessive bleeding: \_\_\_\_\_  YES  NO

Transfusions or receiving blood products: \_\_\_\_\_  YES  NO

Cancer, tumour, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant: \_\_\_\_\_  YES  NO

Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MSRA), sexually transmitted disease (STF), or human immunodeficiency virus (HIV/AIDS) \_\_\_\_\_  YES  NO

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told?  YES  NO

**If YES**, describe: \_\_\_\_\_

What is your primary concern about your child's oral health?: \_\_\_\_\_

**How would you describe the following?**

Your child's oral health?      Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Your child's health?              Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

The oral health of your other children? Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Not applicable \_\_\_\_\_

Is there a family history of cavities  YES  NO **If yes**, indicate all that apply: Mother \_\_\_\_\_ Father \_\_\_\_\_ Brother \_\_\_\_\_ Sister \_\_\_\_\_

**Does your child have a history of any of the following? For each YES response, please describe:**

Inherited dental characteristics: \_\_\_\_\_  YES  NO

Mouth sores or fever blisters: \_\_\_\_\_  YES  NO

Bad Breath \_\_\_\_\_  YES  NO

Bleeding gums: \_\_\_\_\_

Cavities/decayed teeth: \_\_\_\_\_  YES  NO

Toothache: \_\_\_\_\_

Injury to teeth, mouth or jaws: \_\_\_\_\_  YES  NO

Clinching/grinding his/her teeth: \_\_\_\_\_  YES  NO

Jaw point problems (popping, etc.): \_\_\_\_\_  YES  NO

Excessive gagging: \_\_\_\_\_  YES  NO

Sucking habit after one year of age: \_\_\_\_\_  YES  NO

**If yes**, please specify Finger \_\_\_\_\_ Thumb \_\_\_\_\_ Pacifier \_\_\_\_\_ Other \_\_\_\_\_ For how long? \_\_\_\_\_

How often does your child brush his/her teeth? \_\_\_\_\_ times per \_\_\_\_\_ Does someone help your child brush? \_\_\_\_\_  YES  NO

How often does your child floss his/her teeth? Never \_\_\_\_\_ occasionally \_\_\_\_\_ Daily \_\_\_\_\_ Does someone help your child floss? \_\_\_\_\_  YES  NO

What toothpaste does your child use? With the Fluoride \_\_\_\_\_ Without Fluoride \_\_\_\_\_

Does your child regularly eat 3 meals each day? \_\_\_\_\_  YES  NO

Is your child on a special or restricted diet? \_\_\_\_\_  YES  NO

Is your child a "picky eater"? \_\_\_\_\_  YES  NO

Does your child have a diet high in sugars or starches?: \_\_\_\_\_  YES  NO

Do you have any concerns regarding your child's weight?: \_\_\_\_\_  YES  NO

How frequently does your child have the following?

Candy or other sweets product? Rarely \_\_\_\_\_ 1-2 times/day \_\_\_\_\_ 3 or more times/day \_\_\_\_\_ Never \_\_\_\_\_

Chewing gum? Rarely \_\_\_\_\_ 1-2 times/day \_\_\_\_\_ 3 or more times/day \_\_\_\_\_ Never \_\_\_\_\_

Snacks between meals? \_\_\_\_\_  YES  NO

Soft drinks product? Rarely \_\_\_\_\_ 1-2 times/day \_\_\_\_\_ 3 or more times/day \_\_\_\_\_ (\* such as juice, fruit-flavoured drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Is there anything else we should know before treating your child? **If yes, describe:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of Parent/Guardian Relationship to Child**

**DATE**

**Signature of Staff Member reviewing history**

\_\_\_\_\_