Smiles for the Future Pediatric Dentistry & Orthodontics

HEALTH & SOCIAL HISTORY

Patient Name: _____ **Nickname:** _____ **Date of Birth:** _____

1. Does the patient have any health problems (past or present)? □ Yes □ No
   If yes, explain _____
2. Is the patient currently seeing a physician for any problem? □ Yes □ No
   If yes, explain _____
3. Does the patient take any medications? □ Yes □ No
   If yes, list (including dose)_____
4. Does the patient have an allergy to any food, medicine or materials (e.g. antibiotics, latex)? □ Yes □ No
   If yes, explain _____
5. Has the patient ever had a heart murmur, heart defect or rheumatic fever? □ Yes □ No
   If yes, explain _____
6. Has the patient ever been injured, hospitalized or received surgery? □ Yes □ No
   If yes, explain _____
7. Has the patient ever had a blood transfusion? □ Yes □ No
8. Has the patient ever had any of the following:
   - Breathing problems or asthma? □ Yes □ No
   - Airway, tonsil or adenoid problems? □ Yes □ No
   - Blood problems such as sickle cell anemia? □ Yes □ No
   - Easy bleeding or bruising? □ Yes □ No
   - Seizures, dizziness, fainting spells or epilepsy? □ Yes □ No
   - Frequent headaches? □ Yes □ No
   - Frequent cough or tuberculosis (T.B.)? □ Yes □ No
   - Hepatitis or liver problems? □ Yes □ No
   - Stomach, bowel problems or gastric reflux? □ Yes □ No
   - Diabetes, excessive thirst or urination? □ Yes □ No
   - Other endocrine or hormone problems? □ Yes □ No
   - Kidney problems? □ Yes □ No
   - Hives or skin rash? □ Yes □ No
   - AIDS or HIV infection? □ Yes □ No
   - General anesthesia? □ Yes □ No
   - Birth defect or disability? □ Yes □ No
9. Does anyone in the immediate family have a history of allergies, diabetes, etc.? □ Yes □ No
   If yes, explain _____
10. Did the patient have any health problems or illnesses when younger or at birth? □ Yes □ No
    If yes, explain _____
11. Has the patient had any disease, condition or problem not listed above? □ Yes □ No
    If yes, explain _____
12. Does the patient have emotional, behavior or learning problems(e.g. ADD/ADHD)?□ Yes□ No
    If yes, explain _____
13. In which grade is the patient? _____
14. Does the patient fear the pediatrician? □ Yes □ No
15. Has the patient related well to previous dental treatments? □ Yes □ No
16. Does the patient have a history of: (please check)
    □ Thumb/finger sucking □ Lip biting or sucking □ Mouth breathing □ Speech impediment/lisp
    □ Pacifier use □ Tongue thrusting □ Mouth odor □ Grinding teeth at night
    □ Sleeping problems □ Jaw pain/clicking □ Biting hard objects □ Snoring
17. Does the patient's family have a history of: (please check)
    □ Extra or missing teeth _____ □ Orthodontic Problems_____
18. Name and address of patient's PEDIATRICIAN or family physician: _____
    _____ Date of last physical examination: _____
19. May we take bitewing x-rays (cavity detecting x-rays) on your child today? □ Yes □ No
20. May we take panoramic x-ray (growth & development x-ray) today if needed?□ Yes □ No
21. May we give your child a fluoride treatment (MAY NOT be covered by insurance) □ Yes□ No

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TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

_____ _____

Signature of Parent/Legal Guardian Date