Medical & Dental History

NORTH SHORE PEDIATRIC DENTISTRY

Child's Name: ..... Birth Date: ..... M M / D D / Y Y .....

Medical Information

Child's Physician: ..... Telephone: .....

Address: .....

Does your child have a history of allergies/sensitivities/adverse reactions (Penicillin, Latex, etc)?

☐ YES ☐ NO If yes, please explain .....

Does your child have environmental allergies? ☐ YES ☐ NO If yes, please explain .....

Is your child taking any medication? .....

Check off if your child had or still has any of the following?

☐ Heart diseae, murmur or rheumatic fever ? Type .....
If yes, has your child's doctor recommended antibiotics before dental work?
☐ YES ☐ NO

☐ High or low blood pressure?

☐ Hay fever, sinus problem or allergies?

☐ Herpes or cold sores?

☐ Diabetes?

☐ Emotional problems?

☐ Kidney disease?

☐ Cancer, tumors, or other growths?

☐ Radiation or chemotherapy?

☐ Immunological deficiency disease (i.e. AIDS, Leukemia)

☐ Liver disease (hepatitis, jaundice)?

☐ Abnormal bleeding or blood transfusions?
If yes, when .....

☐ Blood disorder? .....

☐ Hearing problems?

☐ Vision Problems?

☐ Thyroid problems?

☐ Lung disease (TB, persistent cough)?

☐ ASTHMA

☐ Epilepsy, seizures, fainting?

☐ Arthritis?

☐ Genetic disorders?If yes, explain
.....

☐ Premature birth?

☐ Significant injuries or hospitalizations?

☐ Any behavioral issues such as Autism, or ADHD? If yes, explain
.....

☐ Any other major illness, surgery, infections or conditions? If yes. explain.
.....

Is there anything else you would like us to know about your child? Any personality or treatment issues? Any special needs?

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Dental Information

Family Dentist: ..... Telephone Number: .....

1. What is your chief concern you would like examined today? Please explain: .....
.....
2. When was your child's last dental checkup and cleaning? .....
3. Has your child experienced any traumatic injuries? ☐ YES ☐ NO
If yes, explain: .....
4. Has your child had any negative experiences with dentists or doctors?
What, if any: .....

I authorize the staff and dentist(s) at North Shore Pediatric Dentistry to examine and/or treat my child.

Signature: ..... **Relationship to child:** ..... **Date:** .....