

# PEDODONTIC HISTORY CHART

Date \_\_\_\_\_

Patient \_\_\_\_\_ Home# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Sex: M \_\_\_\_\_ F \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Father's name \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Mother's name \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Dental Insurance Co. \_\_\_\_\_ Subscriber \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Who is responsible for account? \_\_\_\_\_

Nearest Friend or Relative (Name, Address, Phone #) \_\_\_\_\_

Previous General Dentist (Name, Address, Phone #) \_\_\_\_\_

Reason for changing dentist \_\_\_\_\_

## MEDICAL HISTORY

1. Medical doctor (Name, Address, Phone #) \_\_\_\_\_

2. Is your child in good health? Yes \_\_\_ No \_\_\_

3. Has there been any change in your child's health within the past year? Yes \_\_\_ No \_\_\_

4. Date of last physical exam \_\_\_\_\_

5. Is your child now under medical care? Yes \_\_\_ No \_\_\_

6. Is he/she taking any medications, pills, or drugs? Yes \_\_\_ No \_\_\_ What? \_\_\_\_\_

7. Is he/she allergic to any medications or substance? Yes \_\_\_ No \_\_\_ What? \_\_\_\_\_

8. (Adolescent women) Is the patient pregnant? Yes \_\_\_ No \_\_\_

### MARK AN X IN THE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING:

- |   |   |  |  |  |
|---|---|--|--|--|
| <input type="checkbox"/> Heart Trouble      | <input type="checkbox"/> Scarlet Fever          | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hypoglycemia            | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Thyroid                | <input type="checkbox"/> Psychiatric Care    | <input type="checkbox"/> Hay Fever               | <input type="checkbox"/> Drug Addiction      |
| <input type="checkbox"/> Heart Murmur       | <input type="checkbox"/> Fainting or Dizziness  | <input type="checkbox"/> Sinus Trouble       | <input type="checkbox"/> X-ray or Cobalt Tmt.    | <input type="checkbox"/> Blood Transfusion   |
| <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Frequent Cough     | <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Excessive Thirst    |
| <input type="checkbox"/> Lung Disease       | <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Pain in Jaw Joints  |
| <input type="checkbox"/> Cold Sores         | <input type="checkbox"/> Heart Surgery          | <input type="checkbox"/> Kidney Trouble      | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Cortisone Medicine  |
| <input type="checkbox"/> Fever Blisters     | <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Hepatitis A (Infect.)   | <input type="checkbox"/> Herpes              |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Allergies              | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Epilepsy or Seizures    | <input type="checkbox"/> Bruise Easily       |
| <input type="checkbox"/> Yellow Jaundice    | <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Sickle Cell Anemia  | <input type="checkbox"/> Cerebral Palsy          | <input type="checkbox"/> Hearing Disability  |
| <input type="checkbox"/> Hives or Skin Rash | <input type="checkbox"/> Mental Retardation     |  |  |  |

9. Have you ever had any other serious illness or condition not marked above? Yes \_\_\_ No \_\_\_

Describe in detail \_\_\_\_\_

10. Do you wish to talk to the doctor privately about any problem? Yes \_\_\_ No \_\_\_

\_\_\_\_\_