Washington Township Dental
50 Years of Family Care

Pediatric Medical History

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Child's Full Name: _____ Nickname: _____

Address: _____ Email: _____

Gender: ❑M ❑F Tel: _____ Cell: _____ Parent SS#: _____

Date of Birth: _____ Height: _____ Weight: _____ Date of Last Physical: _____

Primary Physician: Name/ Address/ Phone _____

Medical Specialists: Name/ Address/ Phone _____

☑ Is your child up to date on immunizations against childhood diseases? ..... ❑Y ❑N

☑ Is your child taking any medication, vitamins, or dietary supplements? ..... ❑Y ❑N

List name, dose, how often, start date _____

☑ Has your child ever had a serious injury/surgery or been hospitalized/ER? ..... ❑Y ❑N

List date and describe _____

☑ Has your child ever had a reaction to or problem with an anesthetic? ..... ❑Y ❑N

☑ Has your child ever had a reaction or allergy to an antibiotic or other medication? ..... ❑Y ❑N

☑ Is your child allergic to Latex, foods, dyes, or anything else? ..... ❑Y ❑N

☑ Is your child up to date on immunizations against childhood diseases? ..... ❑Y ❑N

Please mark ☑ Y for "yes" if an item below pertains to your child or mark ☑ N for "no" if the item does not apply to your child.

❑Y	❑N	Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions
❑Y	❑N	Problems with physical growth or development, weight, or history of eating disorder
❑Y	❑N	Sinusitis, chronic adenoid/tonsil infections
❑Y	❑N	Sleep apnea/snoring, mouth breathing, or excessive gagging
❑Y	❑N	Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease
❑Y	❑N	Irregular heart beat or high blood pressure
❑Y	❑N	Asthma, reactive airway disease, wheezing, or breathing problems
❑Y	❑N	Cystic fibrosis
❑Y	❑N	Frequent colds or coughs, or pneumonia
❑Y	❑N	Frequent exposure to tobacco smoke
❑Y	❑N	Jaundice, hepatitis, or liver problems
❑Y	❑N	Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems
❑Y	❑N	Bladder or kidney problems
❑Y	❑N	Arthritis, scoliosis, limited use of arms or legs, or muscle/ joint/ bone problems
❑Y	❑N	Rash/hives, eczema, or skin problems
❑Y	❑N	Impaired vision, hearing, or speech
❑Y	❑N	Developmental disorders, learning problems/delays, or intellectual disability
❑Y	❑N	Cerebral Palsy, brain injury, epilepsy, or seizures
❑Y	❑N	Autism/ autism spectrum disorder
❑Y	❑N	Recurrent/ frequent headaches/ migraines, fainting, or dizziness
❑Y	❑N	Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)
❑Y	❑N	Attention deficit/hyperactivity disorder (ADD/ADHD)
❑Y	❑N	Behavioral, emotional, communication, or psychiatric problems/treatment
❑Y	❑N	History of known abuse (physical, psychological, emotional, or sexual) or neglect
❑Y	❑N	Diabetes, hyperglycemia, or hypoglycemia
❑Y	❑N	Precocious puberty or hormonal problems
❑Y	❑N	Thyroid or pituitary problems
❑Y	❑N	Anemia, sickle cell disease/trait, or blood disorder
❑Y	❑N	Hemophilia, bruising easily, or excessive bleeding
❑Y	❑N	Transfusions or receiving blood products
❑Y	❑N	Cancer, tumor, chemotherapy, radiation therapy, or bone marrow or organ transplant
❑Y	❑N	Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus, methicillin resistant staphylococcus aureas (MRSA), sexual transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS

Provide details for any "Yes" responses above: _____

Is there any other medical history pertaining to this child or his/her family? _____

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

Your child's oral health is... ❑Excellent ❑Good ❑Fair ❑Poor

☑ Do any of the following apply to your child? For each "yes" please describe:

Family history of cavities (who).....❑Y ❑N

Inherited dental characteristics .....❑Y ❑N

Mouth sores or fever blisters.....❑Y ❑N

Bad breath.....❑Y ❑N

Cavities/decayed teeth.....❑Y ❑N

Toothache.....❑Y ❑N

Injury to teeth, mouth, or jaws.....❑Y ❑N

Clenching/grinding.....❑Y ❑N

Jaw/ Joint problems (popping etc.) .....❑Y ❑N

Excessive gagging.....❑Y ❑N

Sucking habit after 1 year of age.....❑Y ❑N ❑Pacifier ❑Thumb ❑Finger ❑Other What age did they stop?

☑ How often does your child brush their teeth?

Does someone help them? ❑Y ❑N

☑ How often does your child floss their teeth?

Does someone help them? ❑Y ❑N

☑ What toothpaste does your child use?

☑ Source of the drinking water at home? ❑City/ Community ❑Private well

Do you use a water filter? ❑Y ❑N Type:

☑ Does your child receive any fluoride sources?

❑Over the counter rinse ❑School fluoride program

❑Pediatrician applied fluoride ❑Prescription fluoride toothpaste

❑Prescription drops/tablets/ vitamins

☑ How frequently does your child have the following?

Candy or other sweets ❑Rarely ❑1-2/day ❑3 or more/day

Products:

Chewing Gum ❑Rarely ❑1-2/day ❑3 or more/day

Type:

Snacks between meals ❑Rarely ❑1-2/day ❑3 or more/day

Usual snack

Soft drinks* ❑Rarely ❑1-2/day ❑3 or more/day

Products

*(*juice, fruit flavored drinks, sodas, sweetened beverages, sports drinks, or energy drinks)*

Any other significant dietary habits?

☑ Is your child on a special or restricted diet? ❑Y ❑N

Describe:

☑ Does your child have a diet high in sugars or carbohydrates? ❑Y ❑N

Describe:

☑ Do you have any concerns regarding your child's weight? ❑Y ❑N

Describe:

☑ Does your child participate in any sports or similar activities? ❑Y ❑N

☑ Does your child wear a mouthguard during these activities? ❑Y ❑N

☑ Has your child been examined or treated by another dentist? ❑Y ❑N

Date of last visit? Were x-rays taken?

Date of last x-rays?

☑ Has your child ever been evaluated by an orthodontist? ❑Y ❑N

When? Any orthodontic treatment done?

☑ Has your child ever had a difficult dental appointment? ❑Y ❑N

Describe:

Is there anything else we should know before treating your child?

The information on both sides of this form is accurate and complete to the best of my knowledge. Any errors or omissions in completing this form are solely my responsibility.

Signature of parent/guardian | *Relationship to Patient* | *Date*

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Email: Washingtontownshipdental@gmail.com

Pediatric Dentistry:
Mary-Kathryn Annuzzi D. M. D.
Annie Creato D. M. D.

Additional Pediatric New Patient History (Initial Visit Only)

Supplemental History Questions for Infant/Toddler (4 and under):

Was your child born prematurely? **__ YES __NO**

If YES, What Week? _____ Weight? _____

How long was your child breast-fed?

__ N/A __less than 6 months __6-11 months __12-17 months __ 18-23 months __ 2 years/more

How long did your child bottle feed?

__ N/A __less than 6 months __6-11 months __12-17 months __ 18-23 months __ 2 years/more

Do/did you feed your child infant formula? **__YES __ NO**

Does/did your child sleep with a bottle? **__YES __ NO**

Does/did your child use a no-spill training cup (sippy cup)? **__YES __ NO**

Child's age (in months) when first tooth appeared in mouth? _____

Has your child experienced any teething problems? **__YES __ NO**

When did you begin brushing his/her teeth?

__ N/A __less than 6 months __6-11 months __12-17 months __ 18-23months __ 2 years/more

When did you begin using toothpaste?

__ N/A __less than 6 months __6-11 months __12-17 months __ 18-23months __ 2 years/more

Who is your child's primary care taker during the day? _____Evening? _____

Name/age siblings at home _____

Print Name of Parent Guardian _____ Relationship to child _____

Signature of Parent/Guardian _____ (Date) _____/_____/_____