Child's Name: DOB:

Gender: ( ) M ( ) F Race/Ethnicity: _____ Height: _____ Weight: _____

Date of last physical examination: _____

Name/address/phone of primary physician: _____

Name/address/phone of medical specialists: _____

	YES	NO
Is your child in Foster Care, Adopted, or under different guardianship than the biological parent?	☐	☐
Is your child being treated by a physician at this time? Reason _____	☐	☐
Is your child up to date on immunizations against childhood diseases?	☐	☐
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?	☐	☐
List name, dose, frequency & date started: (1) _____ : _____ (2) _____ : ____		
(3) _____ : _____ (4) _____ : _____ (5) _____ : ____		
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?	☐	☐
List date & describe: _____		
Has your child ever had a reaction to or problem with an anesthetic? Describe _____	☐	☐
Has your child ever had a reaction or allergy to an antibiotic, sedative, latex or anything else?	☐	☐
List: _____		

Does your child have or have had . . .

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions _____	☐	☐
Problems with physical growth or development _____	☐	☐
Sinusitis, chronic adenoid/tonsil infections _____	☐	☐
Sleep apnea/snoring, mouth breathing, or excessive gagging _____	☐	☐
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease _____	☐	☐
Irregular heart beat or high blood pressure _____	☐	☐
Asthma, reactive airway disease, wheezing, or breathing problems _____	☐	☐
Cystic fibrosis _____	☐	☐
Frequent colds or coughs, or pneumonia _____	☐	☐
Frequent exposure to tobacco smoke _____	☐	☐
Jaundice, hepatitis, or liver problems _____	☐	☐
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems _____	☐	☐
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions _____	☐	☐
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder _____	☐	☐
Bladder or kidney problems _____	☐	☐
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems _____	☐	☐
Rash/hives, eczema or skin problems _____	☐	☐
Impaired vision, hearing, or speech _____	☐	☐
Developmental disorders, learning problems/delays, or intellectual disability _____	☐	☐
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures _____	☐	☐
Autism/autism spectrum disorder _____	☐	☐
Recurrent or frequent headaches/migraines, fainting, or dizziness _____	☐	☐
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) _____	☐	☐
Attention deficit/hyperactivity disorder (ADD/ADHD) _____	☐	☐

What concerns do you have about your child's oral health (cavities, tooth pain,etc.)?

_____

Does your child currently have any sucking habits such as thumb/finger sucking, Pacifier, or other? _____ ☐ ☐

How often does your child brush his/her teeth? _____ times per _____

What type of toothpaste does your child use? ( ) Fluoride ( ) Non fluoride (training)

Is this your child's first time to the dentist? . . . . . ☐ ☐

Date of last visit: _____

Has your child had any problems with dental treatment in the past? . . . . . ☐ ☐

If YES, explain: _____

Signature of Parent/Guardian Date: Doctor's Signature after reviewing Date:

Relationship to child: _____