Eastside Pediatric Dental Group

MEDICAL/DENTAL HISTORY UPDATE

PATIENT NAME:_____Date of Birth:_____Weight_____

Is your child being treated by a physician at this time? Yes No
Reason:_____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? Yes No
LIST DIAGNOSES, name of medication(s), dose, frequency and date started: _____
_____

Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year? Yes No
Describe:_____

Has your child ever had a reaction to or problem with an anesthetic? Yes No
Describe:_____

Has your child ever had a reaction to or allergy to an antibiotic, sedative, or other medication? Yes No
List:_____

Is your child allergic to latex or anything else such as metals, acrylic, or dye? Yes No
List:_____

Is your child allergic to any foods? Yes No
List:_____

Have there recently been any significant changes/disruptions to your child's family, home or school routines? Yes No
Describe:_____

What is your primary concern regarding your child's oral health?
_____

Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? Yes No
Describe:_____

Has your child's diet changed significantly since his/her last dental visit? Yes No
Describe:_____

Has your child been treated by another dentist/dental professional since last visiting our office: Yes No
Reason:_____

Is there any other change in the child's medical, dental, or family history that the dentist should be told? Yes No
Describe:_____

_____	_____	_____	_____
Signature of Parent/Guardian	Relationship to child	Date	Signature of staff member reviewing history