ANCHORAGE PEDIATRIC DENTISTRY

J. Brant Darby, DDS

Medical Questionnaire

ABOUT YOUR CHILD

_____
Child's Name

_____ ☐ M ☐ F _____
Age Date of Birth

REASON FOR THIS VISIT:

_____

REFERRED TO THIS OFFICE BY (We wish to thank them): _____
Full Name Phone number

DENTAL HISTORY

Is this your child's first dental visit? ☐ Yes ☐ No

_____
Previous Dentist City

_____
Date of last visit

Were dental x-rays taken? ☐ Yes ☐ No

If yes when? _____

Any injuries to your child's teeth or jaws?

☐ Yes ☐ No If so, when? _____

History of: When?

Breast feeding _____
Bottle habits _____
Thumb/finger sucking _____
Pacifier _____
Dental grinding/clenching _____

Has your child experienced any unfavorable reaction from previous medical or dental care?

☐ Yes ☐ No (If yes, please explain)

_____

Has your child had recent dental pain? ☐ Yes ☐ No

PREVENTATIVE DENTAL CARE

How often does your child brush? _____

Is tooth brushing supervised? ☐ Yes ☐ No

By whom? _____

Do you help your child brush? ☐ Yes ☐ No

Is dental floss used? ☐ Yes ☐ No

Does your child receive any of the following?

Fluoride in vitamins? ☐ Yes ☐ No
Bottled water? ☐ Yes ☐ No
Fluoride tablets/drops? ☐ Yes ☐ No
Well water? ☐ Yes ☐ No
Fluoridated water? ☐ Yes ☐ No

MEDICAL HISTORY

* Is your child presently under the care of your family physician for any medical reason? ☐ Yes ☐ No If yes, why? _____

_____ _____
Date of last physical exam Family physician's name phone #

*Is your child presently under the care of a specialist for any medical reason? ☐ Yes ☐ No If yes, explain. _____

*Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt, or other medical reason? ☐ Yes ☐ No

*Is your child presently taking medications? ☐ Yes ☐ No

If so, what? _____

*Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No

For what? _____

*Does your child have any allergies to medications, food, latex, other? ☐ Yes ☐ No If so please list here _____

*Has any member of the family, including your child, had a problem with general anesthesia? ☐ Yes ☐ No

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO:

Yes	No		Yes	No	
		Aids-HIV			Excessive gagging
		Anemia			Fainting or dizziness
		Arthritis			Fever blisters
		Asthma			Growth/developmental problem
		Autism			Heart surgery
		Bladder conditions			Headaches
		Blood disease			Hearing/Speech Impairments
		Blood transfusions			Heart Murmur/Defect
		Birth defects			Hemophilia
		Bone or joint problems			Hepatitis/Liver Disease
		Brain injury			High Blood Pressure
		Bruising easily			Kidney Disease
		Cancer			Leukemia
		Cerebral palsy			Mental Disability
		Chemotherapy/radiation			Mouth Sores
		Child abuse			Nutritional Deficiency
		Chronic ear infections			Orthopedic Problems
		Cleft lip/palate			Pain in Jaw Joints
		Congenital heart lesion			Premature Birth
		Convulsions/seizures			Psychiatric Care
		Diabetes			Rheumatic Fever
		Drug addiction			Scoliosis
		Emotional disturbance			Sickle Cell Anemia
		Epilepsy			Tonsil infection
		Eye problems			Tuberculosis