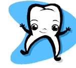
SWEET HOME
PEDIATRIC DENTISTRY



MEDICAL HISTORY

DENTAL HISTORY

1. **Child's Name:** ______________________
2. Reason for today's visit: ______________________
3. Former Dentist ______________ 4. City / State ______________
5. Date of Last dental visit ______________________
6. Has your child had an unfavorable experience in a previous dental(medical) office? ______________
7. Have there been any injuries to your child's teeth or jaws? ______________
8. Does your child receive fluoride vitamins, tablets, water, etc.? ______________
9. Has an orthodontist seen your child? If so, Who? ______________

CHILD'S HABITS

10. Does your child:
    - Suck his / her Thumb / Finger / Lips/ Pacifier .... YES NO
    - Bite / Chew his / her nails or hard objects .... YES NO
    - Grind his / her teeth .... YES NO

MEDICAL HISTORY

11. **Physician's Name:** ______________ Date of last visit ______________ Phone#: ______________

13. Is your child currently under the care of a physician for any medical problem or condition? YES ☐ NO ☐

    If so, please describe ______________________

14. Is your child currently taking any medicine / allergic to any medication ? YES ☐ NO ☐

    Please list name and dosage ______________________

15. Has your child ever been hospitalized or had surgery? YES ☐ NO ☐

    Please describe(for what condition and when) ______________________

17. Has your child ever had any of the following?

YES	NO		YES	NO	
☐	☐	**Asthma**	☐	☐	**Liver Disorder**
☐	☐	**Cancer**	☐	☐	**Kidney Disorder**
☐	☐	**Hepatitis**	☐	☐	**Gastrointestinal Disorder**
☐	☐	**Hemophilia / Blood Disorder**	☐	☐	**Diabetes**
☐	☐	**Rheumatic Fever**	☐	☐	**Congenital Heart Defect**
☐	☐	**Allergies**	☐	☐	**Heart Murmur**
☐	☐	**Epilepsy or Seizures**	☐	☐	**Anemia**
☐	☐	**Tuberculosis**	☐	☐	**Red Dye Allergy**
☐	☐	**ADD / ADHC**	☐	☐	**Latex Allergy**

Was your child born prematurely? By how long?: ______________________

Is your child developmentally delayed, physically handicapped, or have any learning or emotional disabilities? ______________

Please describe any other medical history or problems you feel should be brought to the doctor's attention: ______________

Please list your child's allergies to any medications or foods: ______________________

I HEREBY AUTHORIZE DR. MIN C. DO / DR. HELEN H. DO / HANNAH SONG TO PERFORM A DENTAL EXAMINATION INCLUDING DENTAL X-RAYS, IF NECESSARY, FOR MY ABOVE NAMED CHILD. ANY ADDITIONAL PROCEDURES BEYOND A DENTAL CLEANING WILL BE EXPLAINED TO ME PRIOR TO INITIATION OF SUCH PROCEDURES.

Signature of patient or parent of minor Date **Dentist's Signature** Date

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition	Parent Signature	Dr. Signature