Pediatric Medical and Dental History
Greenpoint Pediatric Dentistry

Patient's Name (Last): First (Initial):
Date of Birth: Gender: □ Male □ Female Height: Weight:
Primary/ Referring Dentist: Last Visit:
Address: Phone Number:
Primary Physician: Last Visit:
Address: Phone Number:

Please mark Yes where applicable. You may give details in the space provided.

Is your child being treated by a physician at this time? □ Yes □ No
If yes, describe:
Is your child taking any medication (prescription or over the counter), vitamins, or supplements? □ Yes □ No
If yes, list name, dose, frequency & date started:

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? □ Yes □ No
If yes, please list and describe:
Has your child ever had a reaction to or problem with an anesthetic, medication, antibiotic, or latex? □ Yes □ No
If yes, describe:
Is your child up to date on immunizations against childhood diseases? □ Yes □ No

Please mark Yes where applicable. Please provide details at the bottom of this list.

Sleep apnea/snoring, mouth breathing, or excessive gagging □ Yes □ No
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease □ Yes □ No
Irregular heart beat or high blood pressure □ Yes □ No
Asthma, reactive airway disease, wheezing, or breathing problems □ Yes □ No
Frequent colds or coughs, or pneumonia □ Yes □ No
Frequent exposure to tobacco smoke □ Yes □ No
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems □ Yes □ No
Rash/hives, eczema or skin problems □ Yes □ No
Impaired vision, hearing, or speech □ Yes □ No
Developmental disorders, learning problems/delays, or intellectual disability □ Yes □ No
Autism/autism spectrum disorder □ Yes □ No
Recurrent or frequent headaches/migraines, fainting, or dizziness □ Yes □ No
Abuse (physical, psychological, emotional, or sexual) or neglect □ Yes □ No
Diabetes, hyperglycemia, or hypoglycemia □ Yes □ No
Hemophilia, bruising easily, or excessive bleeding □ Yes □ No

Provide additional details here. Include any other significant medical history pertaining to this child or his/ her family that you feel the dentist should be told:

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

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Please mark Yes where applicable. Please provide details at the bottom of this list.

Mouth sores or fever blisters ..... □ Yes □ No
Toothache ..... □ Yes □ No
Injury to teeth, mouth or jaws ..... □ Yes □ No
Excessive gagging ..... □ Yes □ No
Sucking habit after one year of age ..... □ Yes □ No
If yes, which: ..... □ Finger/ Thumb □ Pacifier □ Other For how long? .....

Please provide additional information here: .....

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Please mark Yes where applicable. You may give details in the space provided.

Does your child participate in any sports or similar activities? ..... □ Yes □ No
If yes, list: .....
Does your child wear a mouthguard during these activities? ..... □ Yes □ No
If yes, type: .....
Has your child ever had a difficult dental appointment? ..... □ Yes □ No
If yes, please describe: .....
Is there anything else we should know before treating your child? ..... □ Yes □ No
If yes, describe: .....

Parent/ Guardian Signature: ..... **Date**: .....
Relationship to patient: .....
Reviewing Clinician Signature: ..... **Date**: .....