



HEALTH INFORMATION Ages 0-5 Years

Patient Name: _____ Date of Birth: _____ Today's Date: _____

DENTAL HISTORY

Is/was your child breast-fed and/or bottle-fed? (Please circle) | Until age: _____

Does your child take any enhanced formula or fluoride supplements? Yes ☐ No ☐ Describe: _____

Does your child drink juices or sweetened drinks? Yes ☐ No ☐ If yes, what kind: _____

On average, how many times per day does your child snack in between meals? _____

How often does your child brush their teeth? _____ What toothpaste is used? _____

Does your child floss daily? Yes ☐ No ☐ Does an adult assist with the brushing and/or flossing? Yes ☐ No ☐

How do you think your child will react to dental treatment? _____

Has your child had any injuries to teeth, mouth, face, or head? If yes, please describe: _____

Has your child had any of the following habits? If yes, please check Past or Current:

P ☐ C ☐	P ☐ C ☐	P ☐ C ☐	P ☐ C ☐	P ☐ C ☐
Pacifier ☐	Cheek Biting ☐	Lip Sucking ☐	Jaw Clenching ☐	Snoring ☐
Thumb Sucking ☐	Nail Biting ☐	Tongue Thrust ☐	Mouth Breathing ☐	Grinding ☐

Is there clicking, popping, or discomfort in the jaw joints? Yes ☐ No ☐ If yes, when did it begin? _____

MEDICAL HISTORY Current Age: _____ Height: _____ Weight: _____ Pronouns: _____

Is your child taking any medications or drugs? Yes ☐ No ☐ If yes, list: _____

Is your child sensitive or allergic to any drugs, foods, latex products, or other materials? Yes ☐ No ☐

If yes, describe: _____

Has your child ever been hospitalized or had a major operation? Yes ☐ No ☐ If yes, describe: _____

Are your child's immunizations up to date? Yes ☐ No ☐ If no, reason: _____

Child's Pediatrician: _____ Date of Last Visit: _____

Pediatrician Location/Address: _____ Phone #: _____

Our practice believes in integrated oral health care. We will share a summary of our exam findings with your child's pediatrician. Please let us know if you wish to opt out. ☐ Opt Out

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MEDICAL HISTORY

Has your child ever been diagnosed as having any of the following? If yes, please select:

- | | | |
|---|--|--|
| ☐ ADD and/or ADHD | ☐ Congenital Disorders | ☐ Hepatitis |
| ☐ AIDS and/or HIV+ | ☐ Currently Pregnant | ☐ High / Low Blood Pressure |
| ☐ Artificial Joints or Limbs | ☐ Cystic Fibrosis | ☐ Kidney Problems |
| ☐ Asthma / Breathing Problems | ☐ Developmental Delay | ☐ Liver Problems |
| ☐ Autism Spectrum Disorder | ☐ Diabetes Type 1 or Type 2 | ☐ Nutritional Deficiency |
| ☐ Bone Conditions | ☐ Eating Disorders | ☐ Oral Ulcers |
| ☐ Blood Disorders | ☐ Emotional Problems | ☐ Premature Birth |
| ☐ Cancer or Malignancies | ☐ Endocrine Conditions | ☐ Rheumatic Fever |
| ☐ Cerebral Conditions | ☐ Epilepsy or Seizures | ☐ Sinus Problems |
| ☐ Chemotherapy / Radiation | ☐ Excessive Gagging | ☐ Skin Problems |
| ☐ Chronic Adenoid/Tonsil Infection | ☐ Frequent Infections | ☐ Sleep Apnea |
| ☐ Chronic Ear Infections | ☐ Gastrointestinal Issues | ☐ Speech Impediment |
| ☐ Chronic Headaches or Migraines | ☐ Hearing Impaired | ☐ TMJ Disorder |
| ☐ Cleft Lip / Palate | ☐ Heart Conditions | ☐ Tuberculosis |

Please list any other dental or health concerns: _____

To the best of my knowledge, the questions on this form have been answered with accuracy.
I understand that providing incorrect information can be dangerous to the patient's health.
It is my responsibility to inform the dental office of any changes in health.

Parent / Guardian Name (Print): _____

Signature: _____

CLINICAL USE ONLY

Reviewed by: _____