Medical History

Pearland Pediatric Dentistry
2360 County Road 94, Suite 102
Pearland, TX 77584

Patient Name: ____ Date: ________ DOB:___________
Address:____
Nickname: ____________________________________ Gender: Male Female Current Weight:_______
Parents/Guardians: ____
Name and Age of Brothers and Sisters:____
Child's Physician/Pediatrician: _____________________________________ Phone #: _________________
Family Dentist: _________________________________ Dental Insurance Company:__________________
Who may we thank for referring you to our office? ____
Name and kind of child's favorite pet, toy, hobby, or sport? ____
Which school does your child attend (if school-age): ____
Date of last dental exam/treatment: __________________ Where was last dental visit: ______________
What is your chief concern about your child's mouth or teeth?____________________________________

Has child had any of the following? Please check those that apply:

__Anemia	__Chicken Pox	__Jaundice	__Nervous Disorders
__ ADD/ADHD	__Convulsions/Seizures	__Kidney Problems	__Respiratory Problems
__Artificial joints	__Diabetes	__Liver Disease	__Rheumatic Fever
__Asthma	__Epilepsy	__Mental Disorders	__Scarlet Fever
__Bladder disease	__Hearing Disorders	__Malignancies	__Sinus Problems
__Blood Disorders	__Heart Disorders	__Measles	__Thyroid Disorders
__Bleeding Disorders	__Heart Murmur	__Mentally Handicapped	__Tuberculosis
__Cancer	__Hepatitis	__Mononucleosis	__Vision Disorders
__Cerebral Palsy	__High Blood Pressure	__Mumps	__Other:_____________

Is your child in good health? Y N ____
Has your child had any complications following dental treatment? Y N
If yes, please explain: ____
Is your child under the care of a physician? For illness or injury? __________________________________
Please list all medications your child is taking:
____
Please list all allergies to medications (and reactions):____
Please list all other allergies (for example ants, nuts): ____
Has your child been hospitalized? Y N
If yes, please explain: ____
Has your child had surgery? Y N
If yes, please explain: ____
Any history of excessive bleeding? ____
Is your child up to date on immunizations? Y N ____
Does your child have or has he/she had frequent ear and throat infections or tubes in ears? Y N
Has your child had any history of hearing or speech problems? Y N ___________________________
Has mother or father had a lot of tooth decay? Y N ____________________________________
In your family, is there any history of malocclusions, bad bites, missing teeth or extra teeth? Y N
If yes, please explain: ____
Has your child had a toothache recently? Y N Is your child in pain today? Y N
Is your child adopted? Y N Does child live with mother and father? Y N If no, explain________

To the best of my knowledge, all of the preceding answers and information provided are true.

Print Name: __________________________ Signature: _________________________________ Date: ____________
Relationship to patient: ____________________________________
Reviewed by: ____ Date________________________