PIEDMONT
Pediatric Dentistry

Medical and Dental History

Child's Name _____ Date of Birth _____

Please complete the following about your child:
What is the main reason you brought your child to our office?

_____

Who is your child's primary physician? _____

Is your child taking any medications? Yes/No

If yes, what medications? _____

Is your child allergic to anything? Yes/No

If yes, what are they allergic to? _____

Please mark if your child has ever had any of the following:

- ○ Heart Disease including Murmur
- ○ Asthma or other Respiratory Disease
- ○ Jaundice, Hepatitis, Liver Disease
- ○ Diabetes, Thyroid, Endocrine Disease
- ○ Kidney Disease
- ○ Neurologic Disease, Cerebral Palsy
- ○ Seizures
- ○ Anemia, Hemophilia, Bleeding Disorders
- ○ Tuberculosis
- ○ Autism
- ○ Sickle Cell Disease or Trait
- ○ Cancer
- ○ Mental or Developmental Delay
- ○ Speech, Hearing or Sight Disorder
- ○ Immune Disorders/HIV/STD
- ○ Blood Products/Transfusion
- ○ Hospitalization/Surgery
- ○ Serious Illness
- ○ Downs Syndrome
- ○ ADHD/ADD

Please explain any marks or any other medical conditions we should know about:

_____

_____

Is this your child's first dental visit? Yes/No
Is your child having any dental pain? Yes/No
Has your child had a bad dental experience? Yes/No
Has your child had any dental injuries? Yes/No
Does your water have fluoride? Yes/No
Did your child ever fall asleep with a bottle? Yes/No
Does your child have any habits (pacifier, thumb, etc.)? Yes/No

_____ _____
Parent/Legal Guardian Signature Date

By signing this, you are verifying that all information is correct to the best of your knowledge.