EASTMAN INSTITUTE FOR ORAL HEALTH
UNIVERSITY of ROCHESTER MEDICAL CENTER

Pediatric Medical History

Patient Name: _____

Date of Birth: _____

MEDICAL HOME

Who is your child's primary care physician? _____ Doctors Phone #: _____

What is the name of the doctor's practice and its location (city/state)? _____

_____

Is your child currently under the care of the primary care physician for a specific condition? ☐ Yes ☐ No If yes, what condition? _____

_____

Is your child under the care of a pediatric specialist for a medical, emotional, or behavioral condition? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Is the doctor affiliated with the University of Rochester Medical Center? ☐ Yes ☐ No

HOSPITALIZATIONS AND SURGERIES

Was your child born at full term? ☐ Yes ☐ No If no, at how many weeks gestation? _____

Did your child spent time in the Neonatal Intensive Care Unit after birth? ☐ Yes ☐ No If yes, how long? _____

Has your child had surgery? ☐ Yes ☐ No If yes, explain (reason for surgery, date, outcome): _____

_____

Has your child been hospitalized for a medical condition or because of significant injuries? ☐ Yes ☐ No If yes, reason, date, outcome _____

_____

_____

Has your child spent time in the Pediatric Intensive Care Unit? ☐ Yes ☐ No If yes, reason, date, outcome: _____

_____

MEDICATIONS

Is your child presently taking medications prescribed by a doctor? ? ☐ Yes ☐ No If yes, please list _____

_____

_____

Is your child presently taking over the counter medications? ☐ Yes ☐ No If yes, please list _____

_____

ALLERGIES AND ADVERSE REACTIONS

Has your child had a bad reaction to any of the following? Please circle all that apply.

Local anesthetics	Penicillin or other antibiotics	Sedative medications	Sulfa drugs
Codeine or other narcotics	Latex	Hay fever/seasonal allergies	Foods
Metals	Other, please explain: _____		

Explain yes response and describe type of reaction: _____

DISEASES OR CONDITIONS

Does your child have or has had any of the following diseases or conditions?

Complications during pregnancy or at birth? ☐ Yes ☐ No, if yes please explain: _____

Any birth defects or inherited conditions? ☐ Yes ☐ No, if yes please explain: _____

(over)

DISEASES OR CONDITIONS

Does your child have or has had any of the following diseases or conditions?

Any blood or bleeding problems? ☐ Yes ☐ No, if yes please explain: _____

Any ears, eyes, nose, or throat problems? ☐ Yes ☐ No, if yes please explain: _____

Any heart problems? ☐ Yes ☐ No, if yes please explain: _____

Any lung or breathing problems? ☐ Yes ☐ No, if yes please explain: _____

Any nutritional or digestive system problems? ☐ Yes ☐ No, if yes please explain: _____

Any problems in the genitourinary system? ☐ Yes ☐ No, if yes please explain: _____

Any problems with the brain or nervous system? ☐ Yes ☐ No, if yes please explain: _____

Any developmental conditions? ☐ Yes ☐ No, if yes please explain: _____

Any mental and behavioral Conditions? ☐ Yes ☐ No, if yes please explain: _____

Any hormone problems? ☐ Yes ☐ No, if yes please explain: _____

Any bone and muscle problems? ☐ Yes ☐ No, if yes please explain: _____

Any skin problems? ☐ Yes ☐ No, if yes please explain: _____

DENTAL HISTORY

Is today your child's first dental visit? ☐ Yes ☐ No If no, how long since your child's last dental exam? ___months

If no, has your child had dental X-rays taken in the past? ☐ Yes ☐ No When? _____

If your child has seen another dentist, please provide the name of the doctor or office: _____

Has your child ever had an unpleasant dental experience? ☐ Yes ☐ No

DENTAL HEALTH STATUS

How is your child's dental health? ☐ Poor ☐ Average ☐ Excellent

Does your child have dental pain at the present time? ☐ Yes ☐ No

Has your child sought dental care on an emergency basis? ☐ Yes ☐ No

Has your child injured his/her teeth, mouth, or head? ☐ Yes ☐ No

Does your child have or do any of the following? (circle all that apply):

Thumb or finger sucking	Mouth breathing	Nail biting	Lip sucking
Use of baby bottle	Breastfeed	Use a pacifier	Bad breath
Tongue thrusting	Teeth grinding	Drooling	Code sores
Canker sores	Use tobacco		