

## BASKING RIDGE PEDIATRIC DENTISTRY MEDICAL AND DENTAL HISTORY

Child's name: \_\_\_\_\_

Primary physician: \_\_\_\_\_ Address/phone: \_\_\_\_\_ Last visit: \_\_\_\_\_

Medical specialists: \_\_\_\_\_ Address/phone: \_\_\_\_\_ Last visit: \_\_\_\_\_

- Is your child currently on any medications? .....  Y  N Explain \_\_\_\_\_
- Does your child have any serious or chronic illnesses?  Y  N Explain \_\_\_\_\_
- Has your child had any serious injuries or accidents?  Y  N Explain \_\_\_\_\_
- Has your child had any surgeries? .....  Y  N Explain \_\_\_\_\_
- Has your child ever been hospitalized? .....  Y  N Explain \_\_\_\_\_
- Is your child allergic to any medications? .....  Y  N Explain \_\_\_\_\_
- Does your child have any food allergies? .....  Y  N Explain \_\_\_\_\_
- Is your child allergic to latex? .....  Y  N Explain \_\_\_\_\_
- Does your child have any food allergies? .....  Y  N Explain \_\_\_\_\_

**Please mark YES if your child has a history of the following conditions. Please provide details if YES.**

- Heart murmur, congenital heart defect/disease,  
rheumatic fever or heart surgery .....  Y  N Explain \_\_\_\_\_
- Irregular heartbeat or high blood pressure .....  Y  N Explain \_\_\_\_\_
- Asthma, reactive airway disease, breathing disease ..  Y  N Explain \_\_\_\_\_
- Cystic Fibrosis .....  Y  N Explain \_\_\_\_\_
- Liver or problems, hepatitis .....  Y  N Explain \_\_\_\_\_
- Gastroesophageal/acid reflux disease (GERD) .....  Y  N Explain \_\_\_\_\_
- Kidney or bladder problems .....  Y  N Explain \_\_\_\_\_
- Eczema or skin problems .....  Y  N Explain \_\_\_\_\_
- Anemia or bleeding problem .....  Y  N Explain \_\_\_\_\_
- Cancer, tumor .....  Y  N Explain \_\_\_\_\_
- Sleep apnea, snoring, mouth breathing .....  Y  N Explain \_\_\_\_\_
- Diabetes .....  Y  N Explain \_\_\_\_\_
- Thyroid or other gland problem .....  Y  N Explain \_\_\_\_\_
- Autism/Autism spectrum disorder .....  Y  N Explain \_\_\_\_\_
- Mental Health Issues .....  Y  N Explain \_\_\_\_\_
- ADD/ADHD .....  Y  N Explain \_\_\_\_\_
- Developmental disorders/learning problems .....  Y  N Explain \_\_\_\_\_
- Hydrocephaly or placement of a shunt .....  Y  N Explain \_\_\_\_\_
- Cerebral Palsy .....  Y  N Explain \_\_\_\_\_
- Seizures .....  Y  N Explain \_\_\_\_\_
- Problems with eyes or vision .....  Y  N Explain \_\_\_\_\_
- HIV/AIDS .....  Y  N Explain \_\_\_\_\_
- Females: Do you take birth control pills? .....  Y  N Explain \_\_\_\_\_
- Other medical history .....  Y  N Explain \_\_\_\_\_

**BASKING RIDGE PEDIATRIC DENTISTRY  
DENTAL HISTORY**

**Child's Name** \_\_\_\_\_

Is this your child's first visit to the dentist?  Y  N

If no, former dentist \_\_\_\_\_

Address/Phone \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Date of last x-ray \_\_\_\_\_

How many times a day is your child brushing? \_\_\_\_\_ Does someone help your child brush?  Y  N

How many times does your child floss? \_\_\_\_\_ Does someone help your child floss?  Y  N

What type of toothbrush does your child use? \_\_\_\_\_

What toothpaste does your child use? \_\_\_\_\_

What is the source of your drinking water at home?  City  Well  Bottled Water

Please check all the sources of fluoride your child receives:

- Drinking Water  Toothpaste  OTC rinse  Prescription toothpaste/gel  
 Prescription drop/tablets/vitamins  Fluoride varnish by pediatrician  Other: \_\_\_\_\_

Does your child have any speech problems? .....  Y  N Explain \_\_\_\_\_

Does your child have any habits of:

- Thumbsucking  Pacifier  Nail biting  Grinding  Lip sucking

Explain \_\_\_\_\_

Does your child have any TMJ pain? .....  Y  N Explain \_\_\_\_\_

**SUPPLEMENTAL HISTORY QUESTIONS FOR INFANTS/TODDLERS**

Was your child born prematurely? .....  Y  N Explain \_\_\_\_\_

How long was your child bottle-fed? \_\_\_\_\_

Does/Did your child sleep with the bottle? .....  Y  N

If yes, what was in the bottle? \_\_\_\_\_

Does/Did your child use a sippy cup? .....  Y  N

Does/Did your child use a pacifier? .....  Y  N ..... Until what age? \_\_\_\_\_

Do/Did you breastfeed? .....  Y  N ..... Until what age? \_\_\_\_\_

Do/Did you have any issues with breastfeeding? .....  Y  N Explain \_\_\_\_\_

When did you begin brushing his/her teeth? \_\_\_\_\_

When did you begin using toothpaste? \_\_\_\_\_

Child's age when the first tooth appeared in the mouth \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Date