Unity Care NW

DENTAL DEPARTMENT PEDIATRIC MEDICAL HISTORY (Ages 0-18)

CHILD'S NAME _____ DOB: _____

CHILD'S PREFERRED NAME: _____ PREFERRED PRONOUNS: _____

1. Who is the child's medical doctor? _____ Phone # of doctor_____
2. Date of last physical exam? _____
3. List any medicine/drugs taken in the past two years? _____
   _____
4. Has your child ever required antibiotics prior to dental treatment?…….…….. YES NO
5. List any ALLERGIES (medication, latex, food, seasonal, etc.) _____
   _____
6. Has your child been hospitalized or had surgery in the past year?…… YES NO
   IF YES, explain _____

CIRCLE ANY OF THE FOLLOWING WHICH THE CHILD HAD PAST OR PRESENT:

Heart Condition		Other	
Anxiety / Depression	Asthma	Jaw Fracture	Arthritis
Heart Murmur	Tuberculosis (TB)	HIV/AIDS	Artificial Joint
Hemophilia	Diabetes	STDs	Cortisone Medication
High Blood Pressure	Thyroid Disease	Herpes/Cold Sores	Epilepsy or Seizures
Sickle Cell Anemia	Cancer or Tumor	Hepatitis A, B, or C	Developmental Disability
Congenital Heart Disease	Chemotherapy/Radiation	Liver Disease	Cerebral Palsy
Rheumatic Fever	ADHD/ADD	Kidney Trouble	Drug Addiction
Anemia	Autism	Stomach Ulcer	Psychiatric Treatment
Hearing Loss	Sensory Processing Disorder	GERD	Fainting or Dizzy Spells

7. Please list any other disease/condition _____

8. WOMEN: Are you pregnant now? YES NO IF YES, DUE DATE: _____
   Are you practicing birth control? …….. YES NO

DENTAL HISTORY

1. Date of last dental exam? _____ Dentist's name: _____
2. Has the child had any problems associated with any previous dental treatment? …… YES NO
   IF YES, Explain:_____
3. How many times a day are child's teeth brushed? _____ Flossed? _____
   Do you help?……..…..…... YES NO
4. Does child take fluoride drops or tablets? ……..…..… YES NO
5. Does child receive public water from the City of Lynden or Lummi reservation? …..… YES NO

Is there anything else we should know about your child? _____

SIGNATURE PARENT/GUARDIAN: _____ **DATE**:_____

RELATIONSHIP TO CHILD: _____**PRINT NAME**:_____