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 provider? _____ Phone # of Provider_____
2. Date of last physical exam? _____
3. Please list all medications/drugs/supplements_____
   _____
4. Has your child ever taken a pre-medication prior to dental treatment?…….…….. YES NO
5. List any ALLERGIES (medication, latex, food, seasonal, etc.) _____
   _____
6. Has your child been hospitalized or had surgery?……..YES NO

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

Heart Condition	Cystic Fibrosis	Other	Artificial Joint **DATE**:
Heart Murmur	Asthma	STDs	Cortisone Meds/Steroids
Hemophilia	Tuberculosis (TB)	Herpes/Cold Sores	ADHD/ADD
High Blood Pressure	Diabetes **A1C:**____	Hepatitis A, B, or C	Autism
Congenital Heart Disease	Thyroid Disease	Liver Disease	Sensory Processing Disorder
Rheumatic Fever	Cancer or Tumor	Kidney Trouble	Epilepsy or Seizures
Anemia	Chemotherapy/Radiation	Stomach Ulcer	Developmental Disability
Sickle Cell Anemia	Organ Transplant	GERD	Cerebral Palsy
Hearing Loss	Drug Addiction	Arthritis	Anxiety/Depression
Vision Impairment	HIV/AIDS	Jaw Fracture	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? _____
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**:_____