Patient Name:

____

Patient Record #: ______________________

Patient DOB: _________________________

PEDIATRIC MEDICAL HISTORY

MEDICAL HOME

Who is your child's primary care physician? ____

Doctor's Phone #: ___________________ Doctor's Practice Location (city/state): ____

Is your child 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: ____

HOSPITALIZATIONS AND SURGERIES

Was your child born at full term? YES NO If no, at how many weeks gestation? ____________________

Did your child spend time in the Neonatal Intensive Care Unit after birth? YES NO

If yes, how long? ____________

Has your child ever had surgery? YES NO If yes, explain (reason for surgery, date, outcome):

____

Has your child ever been hospitalized for a medical condition or because of significant injuries? YES NO

If yes, explain (reason, date, outcome):

____

Has your child ever spent time in the Pediatric Intensive Care Unit? YES NO

If yes, explain (reason, date, outcome):

____

MEDICATIONS

Is your child presently taking any medications prescribed by a doctor? YES NO

If yes, please list with dosage:

____

____

Is your child presently taking any over the counter medications, vitamins and/or mineral/herbal supplements? 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	Hay fever/seasonal allergies	Latex	Foods	Metals

Other: ____

Explain yes responses and describe type of reaction:

____

DISEASES OR CONDITIONS *Does your child have or has had any of the following diseases or conditions?*

(Explain yes responses in the space provided)

Complications during pregnancy or birth?	YES	NO	____________________
Any birth defects or inherited conditions?	YES	NO	____________________
Any blood or bleeding problems?	YES	NO	____________________
Any ears, eyes, nose or throat problems?	YES	NO	____________________
Any heart problems?	YES	NO	____________________
Any lung or breathing problems?	YES	NO	____________________
Any nutritional or digestive problems?	YES	NO	____________________
Any problems in the genitourinary system?	YES	NO	____________________
Any problems with the brain/nervous system?	YES	NO	____________________
Any developmental conditions?	YES	NO	____________________
Any mental or behavioral conditions?	YES	NO	____________________
Any hormone problems?	YES	NO	____________________
Any bone or muscle problems?	YES	NO	____________________
Any skin problems?	YES	NO	____________________

Other: ____

DENTAL HISTORY

Is today your child's first dental visit? YES NO

If no, how long since your child's last dental exam? ____

If no, has your child had dental x-rays taken in the past? YES NO If yes, 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?

____

DENTAL HEALTH STATUS

How is your child's dental health? EXCELLENT AVERAGE POOR

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? (Please circle all that apply)

Thumb or finger sucking	Mouth breathing	Nail biting	Lip sucking
Breastfeeding	Use a baby bottle	Use a pacifier	Bad breath
Tongue thrusting	Teeth grinding	Drooling	Cold sores
Canker sores	Other: ______________________________		

How would you describe your child's temperament? Easy Difficult Slow to Warm Up

I certify that the above information is true and correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in the information I have provided.

Parent or Guardian Signature ______________________________________ Date ____________________