Date

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PID #

MEDICAL ALERT Y ❑ N ❑

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form.

Child's Name: ______________________________ Preferred to be called: ______________
(Last) (First)

Date of Birth: (D)__________/(M) ________ /(Y)__________ Gender: _____ Height:_____Weight: _______

Address: ______________________________ City: ____________ Postal Code: ________

Telephone: ______________________Email Address: ______________________

Date of last physical examination:______________________________

Emergency Contact Name & Number: ______________________________

Preferred way to be contacted for appointment reminders: Please circle PHONE or EMAIL

How did you hear about us? ______________________________

Has your child been examined or treated by another dentist? ____________________ ☐ YES ☐ NO

Were x-rays taken? ______________________________ ☐ YES ☐ NO

Has your child ever had a difficult dental appointment? ____________________ ☐ YES ☐ NO

How do you expect your child will respond to dental treatment? Very well_____Fairly well ___ Somewhat poorly ___Very poorly ___

Name/phone number of primary physician and/or medical specialists:____________________

Is your child being treated by a physician at this time? Reason____________________ ☐ YES ☐ NO

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements ☐ YES ☐ NO

List name, dose, frequency & date started: ______________________________

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ☐ YES ☐ NO

List date & describe: ______________________________

Has your child ever had a reaction to or problem with an anaesthetic? Describe: ____________________ ☐ YES ☐ NO

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List: ☐ YES ☐ NO

Is your child allergic to latex or anything else such as metals, acrylic, or dye? List:____________________ ☐ YES ☐ NO

Is your child up to date on immunizations against childhood diseases? ☐ YES ☐ NO

MEDICAL HISTORY:

Please mark YES/NO if your child has a history of the following conditions. For each "YES", provide details.

Complications at birth, prematurity, birth defects, syndromes, or inherited conditions:____________________ ☐ YES ☐ NO

Problem with physical growth or development: ______________________________ ☐ YES ☐ NO

Sinusitis, chronic adenoid/tonsil infections: ______________________________ ☐ YES ☐ NO

Sleep apnea/snoring, mouth breathing, or excessive gagging:____________________ ☐ YES ☐ NO

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic disease: ____________________ ☐ YES ☐ NO

Irregular heart beat or high blood pressure: ______ ☐ YES ☐ NO

Asthma, reactive airway disease, wheezing, or breathing problems: ______ ☐ YES ☐ NO

Cystic fibrosis: ______ ☐ YES ☐ NO

Frequent colds or cough, or pneumonia: ______ ☐ YES ☐ NO

Frequent exposure to tobacco smoke: ______ ☐ YES ☐ NO

Jaundice, hepatitis, or liver problems: ______ ☐ YES ☐ NO

Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems: ______ ☐ YES ☐ NO

Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions: ______ ☐ YES ☐ NO

Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder: ______ ☐ YES ☐ NO

Bladder or kidney problems: ______ ☐ YES ☐ NO

Arthritis, scoliosis, limited use of arms or muscle/bone/joint problems: ______ ☐ YES ☐ NO

Rash/hives, eczema or skin problems: ______ ☐ YES ☐ NO

Impaired vision, hearing, or speech: ______ ☐ YES ☐ NO

Developmental disorders, learning problems/delays, or intellectual disability: ______ ☐ YES ☐ NO

Cerebral palsy, brain injury, epilepsy, or convulsions/seizures: ______ ☐ YES ☐ NO

Autism/autism spectrum disorder: ______ ☐ YES ☐ NO

Recurrent or frequent headaches/migraines, fainting, or dizziness? ______ ☐ YES ☐ NO

Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous): ______ ☐ YES ☐ NO

Attention deficit/hyperactivity disorder (ADD/ADHD): ______ ☐ YES ☐ NO

Behavioural, emotional, communication, or psychiatric problems/treatment: ______ ☐ YES ☐ NO

Abuse (physical, psychological, emotional, or sexual) or neglect: ______ ☐ YES ☐ NO

Diabetes, hyperglycemia, or hypoglycemia: ______ ☐ YES ☐ NO

Precocious puberty or hormonal problems: ______ ☐ YES ☐ NO

Thyroid or pituitary problems: ______ ☐ YES ☐ NO

Anemia, sickle cell disease/trait, or blood disorder: ______ ☐ YES ☐ NO

Hemophilia, bruising easily, or excessive bleeding: ______ ☐ YES ☐ NO

Transfusions or receiving blood products: ______ ☐ YES ☐ NO

Cancer, tumour, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant: ______ ☐ YES ☐ NO

Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MSRA), sexually transmitted disease (STF), or human immunodeficiency virus (HIV/AIDS) ______ ☐ YES ☐ NO

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? ☐ YES ☐ NO

If YES, describe: ______

What is your primary concern about your child's oral health?: ______

How would you describe the following?

Your child's oral health? Excellent ______ Good ______ Fair ______ Poor ______

Your child's health? Excellent ______ Good ______ Fair ______ Poor ______

The oral health of your other children? Excellent _____ Good ______Fair _______ Poor ______ Not applicable _____________

Is there a family history of cavities ☐ **YES** ☐ **NO** **If yes**, indicate all that apply: Mother _____Father ____Brother ____Sister____

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics: ____________________ ☐ YES ☐ NO

Mouth sores or fever blisters:____________________ ☐ YES ☐ NO

Bad Breath ____________________ ☐ YES ☐ NO

Bleeding gums:____________________

Cavities/decayed teeth: ____________________ ☐ YES ☐ NO

Toothache: ____________________

Injury to teeth, mouth or jaws: ____________________ ☐ YES ☐ NO

Clinching/grinding his/her teeth: ____________________ ☐ YES ☐ NO

Jaw point problems (popping, etc.): ____________________ ☐ YES ☐ NO

Excessive gagging: ____________________ ☐ YES ☐ NO

Sucking habit after one year of age: ____________________ ☐ YES ☐ NO

If yes, please specify Finger __________ Thumb __________ Pacifier _________ Other __________ For how long? __________

How often does your child brush his/her teeth?_________times per________ Does someone help your child brush?___________ ☐ YES ☐ NO

How often does your child floss his/her teeth? Never ____occasionally ___ Daily____Does someone help your child floss? _____ ☐ YES ☐ NO

What toothpaste does your child use? With the Fluoride _______ Without Fluoride _________

Does your child regularly eat 3 meals each day? ____________________ ☐ YES ☐ NO

Is your child on a special or restricted diet? ____________________ ☐ YES ☐ NO

Is your child a "picky eater"?____________________ ☐ YES ☐ NO

Does your child have a diet high in sugars or starches?: ____________________ ☐ YES ☐ NO

Do you have any concerns regarding your child's weight?: ____________________ ☐ YES ☐ NO

How frequently does your child have the following?

Candy or other sweets product? Rarely _________ 1-2 times/day ________ 3 or more times/day __________ Never __________

Chewing gum? Rarely _________ 1-2 times/day ________ 3 or more times/day __________ Never __________

Snacks between meals? ____________________ ☐ YES ☐ NO

Soft drinks product? Rarely ___________ 1-2 times/day _______ 3 or more times/day __________________(* such as juice, fruit-flavoured drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Is there anything else we should know before treating your child? **If yes, describe:**

____

____

____

Signature of Parent/Guardian Relationship to Child **DATE** **Signature of Staff Member reviewing history**

____________________ ____________________ ____________________