DATE

TorontoKIDSDental

Pediatric Dental Specialists

PID#

799 York Mills Road, Unit 1, Toronto, Ontario M3B 1X6
www.torontokidsdental.ca • info@torontokidsdental.ca
T: 416.224.7228 F: 289.454.4047

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: _____ Prefers 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 anesthetic? 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, ventriculoveus): _____ ☐ 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
Monucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MSRA), sexually transmitted disease (STD), or human immudeficiency 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?
If **YES**,describe: _____ ☐ YES ☐ NO
What is your primary concern about your child's oral health?: _____ ☐ YES ☐ NO

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 response, please describe:
Inherited dental characteristics: _____ ☐ YES ☐ NO
Mouth sores or fever blisters: _____ ☐ YES ☐ NO
Bad Breath: _____ ☐ YES ☐ NO
Bleeding gums:. _____ ☐ YES ☐ NO
Cavities/decayed teeth: _____ ☐ YES ☐ NO
Toothache: _____ ☐ YES ☐ NO
Injury to teeth, mouth or jaw: _____ ☐ YES ☐ NO
Clenching/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 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_____ Never_____ (*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**

_____ _____ _____