**Children's Hospital, Boston**
**Department of Dentistry**
**300 Longwood Avenue**
**Boston, MA 02115**

Telephone: (617) 355-6571

Patient Name:

Date of Birth:

Medical Record Number:

***In order to ensure that your child receives the best care at our clinic, we ask you to carefully complete this form. It is important for us to know about all parts of your child's health history. This form is completely confidential, and will be used only for dental and medical reasons.***

## PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name: ______________________________ Nickname: ___________________ Sex:_________

Age:_____ Birthdate: _____________ Interests/Hobbies/Pets: ___________________________________

Mailing Address: ____________________________ City: _______________ State: ___ Zip: __________

Home Telephone: ____________________________

Mother's Name: ______________________ Occupation: ________________ Work Phone: ____________

Father's Name: ________________________ Occupation: ________________ Work Phone: ___________

Father's address (if different from above) ________________________________________________________

What is the parent's primary language?______________________ The child's?______________________

Date of Adoption, if applicable: _________________

Names and ages of brothers and sisters:___________________________________________________________

_____________________________________________________________________________________

Whom may we thank for referring you?_____________________________________________________________

Whom may we contact in case of emergency?

Name: _____________________________ Relationship: _________________ Phone: _______________

## HEALTH PROVIDERS

Child's Physician/Pediatrician: ________________________________ Phone#: ______________________

Mailing Address: __________________________ City: _________________ State:_____ Zip: __________

Children's Hospital Clinics attended by child: __________________________________________________

Child's Previous Dentist: _______________________________ Phone#: ____________________________

Mailing Address: _____________________________ City: _______________ State:_____ Zip: _________

Patient Name: ______________________________ Medical Record Number:_______________

## MEDICAL HISTORY

**1.** Where there any difficulties during the pregnancy, delivery (e.g., prematurity) or 1st year of your child's life? If yes, describe?____________________________________________ ☐ Yes ☐ No

**2. Medical conditions**: Does your child have any history of the following? *(Check all that apply)*

| ***General conditions*** | ***Developmental*** | ***Infectious*** |
|---|---|---|
| ☐ Arthritis | ☐ Brain injury | ☐ Hepatitis |
| ☐ Asthma | ☐ Cerebral palsy | ☐ HIV infection (AIDS) |
| ☐ Diabetes | ☐ Cleft lip/palate | ☐ Tuberculosis |
| ☐ Gastrointestinal disorders | ☐ Developmental Delay | ☐ Venereal disease: |
| ☐ Heart disease | ☐ Feeding/Eating problems | Type_________________ |
| ☐ Heart murmur | ☐ Growth problems | |
| ☐ Kidney disease | ☐ Hearing loss: Type __________ | ***Substance use/Abuse*** |
| ☐ Rheumatic fever | ☐ Neuromuscular defect | ☐ Drug use |
| | ☐ Orthopedic problems | ☐ Tobacco use |
| ***Behavior/Learning*** | ☐ Seizures: Type______________ | ☐ Abuse (physical or sexual) |
| ☐ ADHD | ☐ Speech prob: Type __________ | |
| ☐ Anxiousness/Nervousness | ☐ Spina bifida | ***Other*** |
| ☐ Autism | | ☐ Cancer: Type _____________ |
| ☐ Behavior issues: Type________ | ***Hematological (Blood-related)*** | ☐ Leukemia: Type ___________ |
| ☐ Emotional disability: | ☐ Anemia | ☐ Fainting/headaches (often) |
| Type________________ | ☐ Bleeding (prolonged) | ☐ Sleep apnea |
| ☐ Learning disability: | ☐ Hemophilia | ☐ Sleep problems |
| Type_________________ | ☐ Sickle cell trait | ☐ Snoring |
| ☐ Psychiatric disorder: | ☐ Sickle cell disease | ☐ Syndrome: Type ___________ |
| Type__________________ | ☐ Transfusion of blood | ☐ Other: ___________________ |

If any boxes checked, please describe further:_______________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**3. Medications**: Is your child CURRENTLY taking any medications?

| Drug | How much & how often? | Reason |
|---|---|---|
| | | |
| | | |
| | | |

**4. Steroid Use:** Has your child had any steroid treatment in the past 6 months? ……………..... ☐ Yes ☐ No

**5. Allergies:** Has your child had any allergic reactions to:

Medications or drugs? ________________________________________________

Latex?_______________________________________________________

Foods? _____________________________________________________

Other? _____________________________________________________

Patient Name: ______________________________ Medical Record Number:_______________

**6. Development/ Special needs:**

Can your child talk and understand at his/her age level?………………………..…… ☐ Yes ☐ No
Does your child attend a special class or school? If yes:_________________________ ☐ Yes ☐ No
Does your child use the following to help with walking? ☐ Wheelchair ☐ Walker ☐ Other
*If female*, has your child had her first monthly period?…………………………….…… ☐ Yes ☐ No

**7. Immunizations:** Are your child's immunizations current?………… …………………… ☐ Yes ☐ No

**8.** Have you ever been told that your child needs to take *antibiotics before dental treatment*? ☐ Yes ☐ No

**9. Hospitalizations:** Has your child ever been hospitalized?……………..………………….. ☐ Yes ☐ No
If yes, when, and where? ________________________________________________
Reason for hospitalization? ______________________________________________

**10. Surgeries:** Has your child had any surgery (operations)?…………………………….. ☐ Yes ☐ No
Date(s) and age(s)? ____________________________________________________
For what reason(s)? ___________________________________________________
Was general anesthesia used?……………………………………………………….. ☐ Yes ☐ No
Were there any complications? If yes: _____________________________________ ☐ Yes ☐ No

**11.** Are there any elevated stresses happening in your home? If yes:____________________ ☐ Yes ☐ No

**12.** Have you or your child ever felt threatened in your home?……………………………… ☐ Yes ☐ No

## DENTAL HISTORY

**13.** Why is your child here today?_________________________________________________________

**14.** If your child has been to a dentist previously:
When was last visit? ______________ Have X-rays been taken? ☐ Yes ☐ No When: _________

**15.** How did your child react?_____________________________________________________________

**16**. Has your child had local anesthetic ("Novocaine"?) ☐ Yes ☐ No
Were there any problems? _____________________________________________________________

**17. Fluoride**: Has your child had fluoride in any of the following forms:
Fluoride tablets or fluoride multivitamins…………………………………………... ☐ Yes ☐ No
Drinking water (community water fluoridation)……………………………………. ☐ Yes ☐ No
Professional topical application…………………………………………………….. ☐ Yes ☐ No

**18. Brushing:** Does your child brush his/her own teeth?…..………..……………………… ☐ Yes ☐ No
When does he/she brush? ☐ A.M. ☐ P.M. ☐ After meals
Do you help in brushing your child's teeth?…………………………………………… ☐ Yes ☐ No
Do you or your child use dental floss in cleaning their teeth?………………………… ☐ Yes ☐ No
What kind of toothbrush does he or she use? ☐ Hard ☐ Soft ☐ Battery

**19. Diet:** Does your child snack frequently?…………..……………………………………... ☐ Yes ☐ No
If yes, what do those snacks usually consist of?_________________________________________
How much soda and juice does your child usually drink per day? ________________

Patient Name: ______________________________ Medical Record Number:_______________

**20. Trauma:** Have your child's *teeth ever been injured*? ☐ Yes ☐ No
When (age)? ________________________________________________
Which teeth? ________________________________________________
Cause? ________________________________________________
Did he/she receive treatment? ☐ Yes ☐ No
If yes, describe treatment ________________________________

**21. Habits**: Does your child have any of the following habits? (Indicate inclusive ages)
Bottle to sleep or nap containing ______________________________ ☐ Yes ☐ No
Thumb or finger sucking……………………………………………………... ☐ Yes ☐ No
Pacifier sucking……………………………………………………………… ☐ Yes ☐ No
Mouth breathing……………………………………………………………… ☐ Yes ☐ No
Grinding of teeth……………………………………………………………… ☐ Yes ☐ No

**22.** Has your child received any unusual dental or surgical treatment to the mouth? ☐ Yes ☐ No
If yes, describe: ________________________________________________

**23.** Is there anything else you would like to tell us?________________________________
________________________________________________________________________

**Signature:**__________________________________**Relationship:**______________**Date:**________

*(office use only)*

*Reviewed by*: Doctor________________________________ Date:_______________

*Review of History:*

________________________________________________________________________
________________________________________________________________________
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