PEDIATRIC MEDICAL HISTORY UPDATE

EverGrins
DENTAL + ORTHO

Child's legal name _____ Nickname _____ Date of Birth _____

Age _____ Gender ☐ F ☐ M ☐ Other _____ Preferred pronouns _____

Parent/Guardian Name _____

Relationship to Patient _____ Phone _____

Primary Physician _____ Phone _____ Date of last visit _____

Medical Specialists _____ Phone _____ Date of last visit _____

Does your child have any medical conditions? ☐ No ☐ Yes

Describe: _____

Is your child being treated by a physician at this time? ☐ No ☐ Yes

Reason: _____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ☐ No ☐ Yes

List name, dose: _____

Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year? ☐ No ☐ Yes

Describe: _____

Has your child ever had a reaction to or problem with an anesthetic? ☐ No ☐ Yes

Describe: _____

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? ☐ No ☐ Yes

List: _____

Does your child have any allergies? (Ex. latex, foods such as nuts or dairy, metals, dyes, acrylic) ☐ No ☐ Yes

List: _____

Have there recently been any significant changes/disruptions to your child's family, home, or school routines? ☐ No ☐ Yes

Describe: _____

What is your primary concern regarding your child's oral health? ☐ No ☐ Yes

Describe: _____

Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? ☐ No ☐ Yes

Describe: _____

Has your child's diet changed significantly since his/her last dental visit? ☐ No ☐ Yes

Describe: _____

Has your child been treated by another dentist/dental professional since last visiting our office? ☐ No ☐ Yes

Reason: _____

Is there anything else in the patient's medical history that the dentist should know about? ☐ No ☐ Yes

Describe: _____

Signature of Parent/Guardian _____ **Date** _____

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Mon-Thu 7:00 am – 4:30 pm / Fri-Sun CLOSED