Kids R Us Dentistry

SANDRA P. SCHWANN, BS, DDS, Cert.(PedDent), FRCD(C), dip. ABPD

PEDIATRIC DENTISTRY MEDICAL/DENTAL HISTORY

These questions are of great value in aiding me to better understand your child.
Please complete each question on both sides of this form. All answers are kept CONFIDENTIAL.
Please utilize space at the end of the questionnaire to elaborate on any of these questions.

Child's Name_____ Nickname, if any _____
(FIRST) (MIDDLE) (LAST)

Age_____ Date of Birth_____ Sex (F)_____(M)_____ Place of Birth_____
(month) (day) (year)

What is your child's developmental age? _____ Attends What School_____ Grade_____

Name and Age of brothers / sisters_____

Child's Primary Physician or Pediatrician _____ Family Dentist _____

Father (Full Name) _____ Cell_____ Email _____

Mother (Full Name)_____ Cell_____ Email _____

Home Address_____ City _____ Postal Code _____ Telephone _____

Father Employed_____ Telephone_____ Ext_____
(Name of Firm) (Position)

Mother Employed_____ Telephone_____ Ext_____
(Name of Firm) (Position)

Dental Insurance: Father _____ Date of Birth _____ Policy / Group No. _____ I.D.#_____

Mother _____ Date of Birth _____ Policy / Group No. _____ I.D.#_____

Which Parent/Guardian will be responsible for payment of this account?_____

If you have previously completed this form for another child, please give that child's name: _____

How did you find out about our office: _____

Evaluation of Senses:

Speech: Typical_____ Sensitive_____ **Visual**: Typical_____ Sensitive_____ **Touch**: Typical_____ Sensitive_____
Smell: Typical_____ Sensitive_____ **Taste**: Typical_____ Sensitive_____

Communication:

How does Patient Communicate?_____ Verbal Direction (words) _____
Visual Direction (Prompting) _____ Physical Direction (Herding) _____

Activities of Daily Life:

Toilet: Independent___ Needs Assistance___ **Eating:** Independent___ Needs Assistance___ **Taking Medication:** Good___ Resistant___

Dental History:

What is the reason for this visit? _____

When did this child last receive dental treatment? _____

Has your child had any unfavourable experiences in a dental or medical office? _____

Please Describe: _____

How would your describe your child's temperament? _____

Does your child have any habits which may affect the teeth or mouth?

Breathes through mouth _____ Sucks thumb / fingers _____ Pacifier Habit _____ Grinds Teeth _____
Tongue Habit _____ Other _____

Does your child experience pain in the jaws or experience headache while chewing? _____
How often does your child brush his/her teeth? _____ times/day When? _____ After each meal? _____
How often does your child floss his/her teeth? _____ Brand of toothpaste used _____
Has your child had fluorides of any sort?
Topical application to teeth_____ How often? _____ Date of last one_____
Drops or tablets_____ How often? _____ How many _____
Does your child take a vitamin supplement containing fluoride? (YES it does)_____ (NO it does not)_____ (I'm not sure)_____
Have dental x-rays been taken of this child? _____ (NO) _____(YES) When? _____ Where? _____
How was this child fed after birth (bottle, breast, milk, formula)? _____Is your child still bottle or breast fed?_____
Does your child tolerate milk and other foods well? _____
At what age did your child completely give up the bottle? _____
Was a pacifier used as an infant? (YES) _____ (NO) _____ is it still being used? _____

Medical History:

Is this child adopted? If so, this may possibly affect the extent of medical history and/or understanding of familiar growth pattern and cavity susceptibility. _____(YES) _____ (NO)_____

Were any problems experienced during pregnancy or delivery with this child? (medical, dietary) _____

_____

Did this child have any problems during the first two years of life? (medical, dietary) _____

_____

Has your child had any of the following:

	YES	NO		YES	NO
Measles (rubeola)	_____	_____	Cold Sores (herpes simplex)	_____	_____
German Measles (rubella)	_____	_____	Canker Sores (apthous ulcers)	_____	_____
Chicken Pox (varicella)	_____	_____	Mumps	_____	_____
Hepatitis (infectious) (HEP-A)	_____	_____	Infectious Mononucleosis	_____	_____
(Serum) (HEP-B)	_____	_____	Thrush (monilial infection)	_____	_____

Has your child ever been hospitalized? _____ (NO) _____ (YES) When/where _____
For what reason? _____
Has your child ever had a blood transfusion or been given blood product? _____ (NO) _____ (YES)
For what reason? _____ When _____
Have you or your child been tested POSITIVE for the HIV virus? _____ (NO) ____ (YES) Who/When?_____
Is your child under the care of a cardiologist? _____ (NO) _____ (YES) Name: _____
Has the cardiologist or your family doctor informed you of your child's need to be placed on prophylactic antibiotic therapy prior to his/her dental procedures? _____

Has your child had any history of: (please mark **Y** for Yes and **N** for No)

ALLERGIES/DERMAL
- Food _____
- Pollen _____
- Drug _____
- Latex(Rubber) _____
- Arthritis _____
- Artificial Joint _____

HEART DISEASE
- Rheumatic _____
- Congenital _____
- Other Heart or Blood Vessel Problems _____

GENITOURINARY DISORDER
- Bladder _____
- Kidney _____
- Other_____

IMMUNOLOGICAL DISORDER _____
LEARNING DISORDER _____
PHYSICAL DISORDER _____
EMOTIONAL DISORDER _____
TRAUMA OR ACCIDENT _____
HISTORY OF ABUSE OR NEGLECT _____
SPEECH PROBLEMS _____
TUMOR OR CANCER _____
CHEMOTHERAPY _____
COBALT TREATMENT _____
DISEASE/PROBLEM OR CONDITION NOT LISTED
IF YES, LIST_____
_____

BLEEDING DISORDER
- Increased Bruising _____
- Tendency to Bleed longer than normal _____
- Anaemia _____
- Hemophilia _____
- Sickle Cell (Anaemia) _____

RESPIRATORY DISORDER
- Asthma _____
- Cystic Fibrosis _____
- Tuberculosis _____
- Chronic cough _____
- Other Lung or Breathing Difficulties _____

ENDOCRINE DISORDER
- Thyroid Disease _____
- Diabetes Mellitus _____
- Diabetes Insipidus _____

GASTRO-INTESTINAL DISORDER
- Stomach/Intestinal Ulcers _____
- Liver: Jaundice _____
- Hepatitis _____
- Other Liver Disease_____
- Persistent Diarrhea _____

NEURAL/SENSORY
- Eye Problems _____
- Epilepsy, Seizures or Convulsions _____
- Psychiatric Treatment _____

Has your child had unfavourable reaction to drugs? _____(NO)_____(YES)

Is your child presently on medication? If yes, describe/dosage _____

IF YES TO ANY OF THE ABOVE, PLEASE DESCRIBE: _____

_____

CONSENT HISTORY TO TREATMENT

It is necessary that a signed permission be obtained from a parent or guardian before any and/all necessary dental services can be started, because your child is a minor. Authorization is hereby granted as such. If during the course of such treatment, in Dr. Schwann's opinion and judgment, any treatment or procedure different from that now contemplated should be indicated in respect of which there is no reasonable opportunity for additional explanation and authorization, you further request and authorize them to do whatever they consider advisable. Furthermore, the individual indicated on this form will be responsible for any account incurred on this child for dental treatment and understand that the account is due at each appointment, or whatever arrangement has been previously mutually agreed upon with Dr. Schwann.

NAME OF PARENT/GAURDIAN (Please print) _____Relationship: _____

SIGNATURE OF PARENT/GAURDIAN _____ Date: _____