Mālama I Ke Ola Dental Pediatric Medical History Form

Child's Legal Name: _____ Date of birth: ___/___/___
Last First Middle

Birth sex: ☐ **M** ☐ **F** Height: _____ Weight: _____

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

Name of the doctor: _____ Contact Information: _____

Reason: _____

Is your child taking any medications (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? ☐ **YES** ☐ **NO**

Describe:

_____

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medications?

☐ **YES** ☐ **NO**

List:

_____

_____

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

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

Is your child immunized against human papillomavirus (HPV)? ☐ **YES** ☐ **NO**

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

	YES	**NO**
Complications before or during child birth, prematurity, birth defects, syndromes, or inherited conditions		
Problems with physical growth or development		
Sinusitis, chronic adenoid/tonsil infections		
Sleep apnea/snoring, mouth breathing, or excessive gagging		
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease		
Irregular heart beat or high blood pressure		
Asthma, reactive airway disease, wheezing, or breathing problems		
Cystic fibrosis		
Frequent colds or coughs, or pneumonia		
Frequent exposure to tobacco or smoke		
Jaundice, hepatitis, or liver problems		
Gastroesophageal/acid reflux, disease (GERD), stomach ulcer, or intestinal problems		
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions		
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder		
Bladder or kidney problems		
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis		
Rash/hives, eczema, or skin problems		
Impaired vision, visual processing, hearing, or speech		
Developmental disorders, learning problems/delays, or intellectual disability		
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures		
Autism/autism spectrum disorder		
Recurrent or frequent headaches/migraines, fainting, or dizziness		
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)		
Attention deficit/hyperactivity disorder (ADD/ADHD)		
Behavioral, emotional, communication, or psychiatric problems/treatment		
Abuse (physical, psychological, emotional, or sexual) or neglect		
Diabetes, hyperglycemia, or hypoglycemia		
Precocious puberty or hormonal problems		
Thyroid or pituitary problems		
Anemia, sickle cell disease/trait, or blood disorder		

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Hemophilia, bruising easily, or excessive bleeding		
Transfusions or receiving blood products		
Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant		
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS		

Provide details here: _____

_____

_____

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: _____

_____

_____

_____ _____ _____

Signature of Parent/Guardian Relationship to Child Date