Dr. John A. Hendry & Associates

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A PROFESSIONAL DENTAL CORPORATION

Pediatric Medical History

Child's legal name:____________________ Nickname:____________________ Date of birth: ___/___/___

Birth sex: ☐M ☐F Current gender identity:_______ Race/Ethnicity____________ Preferred language:_________
Height: ____cm Weight: ___kg
Name/age and relationship of others living in the household:____
____
Primary physician:____________________________ Address/phone:______________________ Last visit:_________
Medical specialists:___________________________ Address/phone:______________________ Last visit:_________
____________________________ ______________________ _________

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 all immunizations?..☐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 the list. Mark NO after each line if none of these conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions.................................☐YES ☐NO

Problems 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 heart 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 coughs, 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

Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis.............................☐YES ☐NO

Rash/hives, eczema, or skin problems……☐YES ☐NO

Impaired vision, visual processing, 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, ventriculovenous)……………………………………☐YES ☐NO

Attention deficit/hyperactivity disorder (ADD/ADHD)……………………………………………………………………………………………☐YES ☐NO

Behavioral, 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, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant………………………☐YES ☐NO

Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV/AIDS)…………………………………………………………☐YES ☐NO

PROVIDE DETAILS HERE: ____

____

____

Is there any other significant medial information 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	Signature of staff