



DENTAL PATIENT INFORMATION AND HEALTH HISTORY FORM

Department of Dentistry
Page 1 of 4

Telephone: (617) 355-6571

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

Child's Name: Nickname: Sex:

Age: Birth date: Interests/Hobbies:

Child's Main Residential or Mailing Address (could be PO Box): City: State: Zip:

Home Telephone:

Mother's Name: Occupation: Work Phone:

Cell: Email:

Father's Name: Occupation: Work Phone:

Cell: Email:

What is the best form of contact?

What is the best way to reach you?

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 call in case of emergency?

Name: Relationship: Phone:

Child's Physician/Pediatrician: Phone#:

Mailing Address: City: State: Zip:

Has child been a patient at Children's Hospital Clinics in the past (or presently): Y N

Which clinic(s)?:

Child's Previous Dentist: Phone#:

Mailing Address: City: State: Zip:

BOSTON CHILDREN'S HOSPITAL, 300 LONGWOOD AVE., BOSTON, MA 02115

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**MEDICAL HISTORY**

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

|   |  |   |
|---|--|---|
| <p><b>General conditions</b></p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Gastrointestinal disorders</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> Rheumatic fever</p> <p><b>Behavior/Learning</b></p> <p><input type="checkbox"/> ADHD/ADD</p> <p><input type="checkbox"/> Anxiousness/Nervousness</p> <p><input type="checkbox"/> Autism</p> <p><input type="checkbox"/> Behavior issues: Type _____</p> <p><input type="checkbox"/> Emotional problems:<br/>Type _____</p> <p><input type="checkbox"/> Learning problems:<br/>Type _____</p> <p><input type="checkbox"/> Psychiatric disorder:<br/>Type _____</p> | <p><b>Developmental</b></p> <p><input type="checkbox"/> Brain injury</p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Cleft lip/palate</p> <p><input type="checkbox"/> Down Syndrome</p> <p><input type="checkbox"/> Developmental delay</p> <p><input type="checkbox"/> Feeding/Eating problems</p> <p><input type="checkbox"/> Growth problems</p> <p><input type="checkbox"/> Hearing loss: Type _____</p> <p><input type="checkbox"/> Eye problems:<br/>Type _____</p> <p><input type="checkbox"/> Neuromuscular defect</p> <p><input type="checkbox"/> Orthopedic problems</p> <p><input type="checkbox"/> Seizures:<br/>Type _____</p> <p><input type="checkbox"/> Speech problem:<br/>Type _____</p> <p><input type="checkbox"/> Spina bifida</p> <p><b>Hematological (Blood-related)</b></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Bleeding (prolonged)</p> <p><input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> Sickle cell trait</p> <p><input type="checkbox"/> Sickle cell disease</p> <p><input type="checkbox"/> Transfusion of blood</p> | <p><b>Infectious</b></p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> HIV infection (AIDS)</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Sexually Transmitted Disease (STD)<br/>Type _____</p> <p><b>Substance use/Abuse</b></p> <p><input type="checkbox"/> Drug use</p> <p><input type="checkbox"/> Tobacco use</p> <p><input type="checkbox"/> Exposure to smoking</p> <p><input type="checkbox"/> Abuse (physical or sexual)</p> <p><input type="checkbox"/> Bullying</p> <p><b>Other</b></p> <p><input type="checkbox"/> Cancer: Type _____</p> <p><input type="checkbox"/> Leukemia: Type _____</p> <p><input type="checkbox"/> Thyroid problem: Type _____</p> <p><input type="checkbox"/> Fainting/headaches (often)</p> <p><input type="checkbox"/> Sleep apnea</p> <p><input type="checkbox"/> Sleep problems</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Syndrome: Type _____</p> <p><input type="checkbox"/> Other: _____</p> |
|---|--|---|

If any boxes checked, please describe further: \_\_\_\_\_

**2. Medications:** Is your child CURRENTLY taking any medications including prescription and/or non-prescription drugs or vitamins? ..... Yes  No

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

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

**4. Allergies:** Has your child had any known allergic reactions? ..... Yes  No

If yes to above, please list (please include any food or drug allergy): \_\_\_\_\_

**DENTAL PATIENT INFORMATION AND HEALTH HISTORY FORM**

Department of Dentistry

Page 3 of 4

CHILD'S NAME

NAME

DOB

**5. Development/Special needs:**

Can your child talk and understand at his/her age level? ..... Yes  No

Does your child go to a special class or school? Yes  No  If yes, type: \_\_\_\_\_

Does your child use the following to help with walking? Wheelchair  Walker  Other

**6. Immunizations:** Are your child's immunizations current? ..... Yes  No

If No to above, why \_\_\_\_\_

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

**8. Hospitalizations:** Has your child ever been hospitalized? ..... Yes  No

If yes, reason for hospitalization? \_\_\_\_\_

**9. Surgeries:** Has your child had any surgery (operations)? ..... Yes  No

For what reason(s)? \_\_\_\_\_

Was your child put to sleep? ..... Yes  No

Were there any complications? If yes, please explain? \_\_\_\_\_ Yes  No

**10.** Have you or your child ever felt threatened in your home or are there any elevated stresses happening in your home? ..... Yes  No

**DENTAL HISTORY**

**11.** Why is your child here today? \_\_\_\_\_

**12.** If your child has been to a dentist previously:

When was last visit? \_\_\_\_\_ Have X-rays been taken? Yes  No  When: \_\_\_\_\_

**13.** How did your child react? \_\_\_\_\_

**14.** Has your child had local anesthesia ("Novocaine")? ..... Yes  No

Were there any problems? \_\_\_\_\_

**15.** Is your child receiving/using any of the following below?

Fluoride tablets or fluoride multivitamins? ..... Yes  No

Fluoridated drinking water (community water fluoridation)? ..... Yes  No

Professional topical application (Fluoride rinse or gel)? ..... Yes  No

**16. 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

Does your child use dental floss or do you floss your child's teeth? ..... Yes  No

What kind of toothbrush does he or she use? Hard  Soft  Battery Operated

What kind of toothpaste does he or she use? \_\_\_\_\_; Does it contain fluoride? Yes  No  Unsure

**17. Diet:** How many times per day does your child eat or have a snack? \_\_\_\_\_

What type of snacks? \_\_\_\_\_

How much and how often does your child usually drink per day of the following: Milk \_\_\_\_\_  
Juice \_\_\_\_\_  
Soda \_\_\_\_\_  
Water \_\_\_\_\_

**DENTAL PATIENT INFORMATION AND HEALTH HISTORY FORM**

Department of Dentistry

Page 4 of 4

DATE RECEIVED

NAME

CHILD NO.

**18. 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 \_\_\_\_\_

**19. Habits:** Does your child have any of the following habits? (Indicate what age range)

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

**20.** Is there anything else you would like to tell us? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ I acknowledge that I have read and fully understand the Boston Children's Hospital Department  
(Initials) of Dentistry's attendance policy

\_\_\_\_\_  
Patient / Parent / Guardian Signature  
(If patient under 18 years of age)

\_\_\_\_\_  
Print

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

**FOR COMPLETION BY DENTIST**

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Dentist  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time