MISKOVICH DENTAL CLINIC P.C.

CHILD MEDICAL AND DENTAL QUESTIONNAIRE

MEDICAL INFORMATION

If "YES" to any of the following items or if you are unsure, please explain below

GROWTH AND DEVELOPMENT — YES / NO

1. Were there any complications during pregnancy or was child premature at birth? ☐ ☐
2. Has the child had psychological counseling or is counseling being considered for the near future? ☐ ☐
3. Any learning, behavioral, excessive nervousness, or communication problems? ☐ ☐
4. Any problems with physical growth? ☐ ☐

CENTRAL NERVOUS SYSTEM

5. Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness? ☐ ☐
6. Any history of injury to the head? ☐ ☐
7. Any sensory disorders? (seeing, hearing) ☐ ☐

CARDIOVASCULAR SYSTEM

8. Any history of congenital heart disease, heart murmur or other heart damage (e.g. rheumatic fever)? ☐ ☐
9. Has any heart surgery been done or recommended? ☐ ☐
10. Any history of chest pains or high blood pressure? ☐ ☐

HEMATOPOIETIC AND LYMPHATIC SYSTEMS

11. Has your child ever had a blood transfusion or blood products transfusion? ☐ ☐
12. Any history of anemia or sickle cell disease? ☐ ☐
13. Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts? ☐ ☐
14. Is your child more susceptible to infections than other children are? ☐ ☐
15. Is there any history of tender or swollen lymph nodes or glands? ☐ ☐

RESPIRATORY SYSTEM

16. Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty in breathing? ☐ ☐

GASTROINTESTINAL SYSTEM — YES / NO

17. Any history of stomach, intestinal, or liver problems? ☐ ☐
18. Any history of hepatitis or jaundice? ☐ ☐
19. Any history of eating disorders, such as anorexia nervosa (binge/purge) or bulimia (binge)? ☐ ☐
20. Any history of unusual weight loss/gain? ☐ ☐

GENITOURINARY SYSTEM ☐ ☐

21. Any history of urinary tract infections, bladder, or kidney problems? ☐ ☐
22. Is the patient pregnant or possibly pregnant? ☐ ☐

ENDOCRINE SYSTEM

23. Any history of diabetes? ☐ ☐
24. Any history of thyroid disorders or other glandular disorders? ☐ ☐

SKIN

25. Any history of skin problems? ☐ ☐
26. Any history of cold sores (herpes) or canker sores (aphthae)? ☐ ☐

EXTREMITIES

27. Any limitations of use of arms or legs? ☐ ☐
28. Any arthritis or other joint problems? ☐ ☐
29. Any problems with muscle weakness or muscular dystrophy? ☐ ☐

ALLERGIES

30. Is your child allergic to any medications? ☐ ☐
31. Any hay fever, hives, or skin rashes caused by allergies? ☐ ☐
32. Any other allergies? ☐ ☐

Explanation:

NAME, ADDRESS & PHONE NUMBER of your child's medical doctor ____________________

MEDICATIONS OR TREATMENTS Is your child currently taking any medication (prescription or non-prescription medicine)? YES ☐ NO ☐

If yes, Medication(s): ____________ Dosage ________ Times Per Day ________

____________ ________ ________

HOSPITALIZATIONS Has your child ever been hospitalized? YES ☐ NO ☐

____________ (Hospital) ________ (Date) ____________ (Reason)

IMMUNIZATIONS Is your child presently protected by immunization against DPT [diptheria, whooping cough (pertussis), Tetanus], polio, measles, mumps, and German measles (rubella)? YES ☐ NO ☐

Please check any of the following that your child has now, has recently been exposed to, or has had in the past

	YES	NO
Immune deficiency diseases including HIV/AIDS	☐	☐
Chicken pox (varicella)	☐	☐
Earache (otitis)	☐	☐
Eye infection (conjunctivitis)	☐	☐
German measles or 3-day measles (rubella)	☐	☐
Glandular fever or mono (infectious mononucleosis)	☐	☐
Measles (rubeola)	☐	☐
Mumps (parotitis)	☐	☐
Scarlet fever (scarlatina)	☐	☐
Sore throat (tonsillitis or pharyngitis)	☐	☐
Substance abuse, alcoholism, drug addiction	☐	☐
Upper respiratory infection (URI), or common cold (pharyngitis, rhinitis, sinusitis, or tonsillitis)	☐	☐
Sexually transmitted diseases	☐	☐

ORAL HEALTH HISTORY

	YES	NO
Does your child have a toothache or other immediate dental problem?	☐	☐
Has your child ever had a toothache?	☐	☐
Has your child had any injury to the mouth, teeth, or jaws (fall, blow, etc.)?	☐	☐

Date of last dental visit ________________

Date of last dental x-rays ________________

	YES	NO
Is this the first dental visit for your child?	☐	☐
Has your child ever had an unfavorable dental experience?	☐	☐
Is (was) your child nourished by nursing beyond one year of age?	☐	☐

If yes, check: Breast ______ Nursing bottle _______
To what age?__________

	YES	NO
Does your child eat a well-balanced diet?	☐	☐

If no, what foods or food groups are not adequate?
____

	YES	NO
Does (or has) your child have (or had) sucking habit beyond one year of age?	☐	☐

If yes, check: Thumb(s) ______ Finger(s) ______
Pacifier ______ Other ____________

	YES	NO
Does (or has) your child have (or had) frequent headaches or pain in or about the ears, eyes, or cheeks?	☐	☐
Does (or has) your child have (or had) any other oral habits beyond one year of age?	☐	☐

If yes, check: Lip Biting _____ Mouth Breathing _____
Nail Biting _____ Teeth Grinding _____ Other ___________

Please explain if you answered "YES" to, or are uncertain about, any of the above items: ______________________
____
____

How often is tooth brushing performed?
__________ time(s) per ____________

	YES	NO
Does your child use dental floss?	☐	☐
Does someone assist your child with brushing and cleaning the teeth?	☐	☐
Does someone inspect for thoroughness after the procedure?	☐	☐
Does your child use a fluoride toothpaste?	☐	☐
Has your child ever had a fluoride treatment?	☐	☐
Has your child ever taken a fluoride supplement or vitamins with fluorides?	☐	☐
Does your child drink tap water?	☐	☐
Does your child drink bottled water?	☐	☐

MEDICAL/DENTAL HEALTH UPDATE - Please verify changes in your health status at regular intervals.

Date	Change in Health Status	Signature	Date	Change in Health Status	Signature
__________	☐Yes ☐No	____________	__________	☐Yes ☐No	____________
__________	☐Yes ☐No	____________	__________	☐Yes ☐No	____________

Father's Name ______________________________ Age _______ Marital Status:

Mother's Name ______________________________ Age _______ S M W D Sep

Brothers (names and ages) ______________________________

Sisters (names and ages) ______________________________

Pets ____________________ Hobbies ____________________

Reason for visit: ______________________________

To the best of my knowledge, the above information is complete and correct.

______________________________ ______________

Signature - Patient (or parent/guardian if patient is under age 18) Date