HESTER PEDIATRIC DENTISTRY P.A.

Medical and Dental History date: _____

Child's First Name _____ **MI** _____ **Last Name** _____

DOB _____ **Gender** _____ **Pediatrician** _____

What is the reason for today's visit and chief complaint?: _____

MEDICAL HISTORY

Is your child taking any medications (prescription and/or over the counter)?	Y N	Please List	_____
Is your child allergic to any medications (antibiotics, anesthetics etc.)?	Y N	Please List	_____
Is your child allergic to any foods or materials (latex, metals, etc.)?	Y N	Please List	_____
Has your child ever been hospitalized or had surgery?	Y N	Please List	_____
Does your child have any health problems?	Y N	Please List	_____
Is your child subject to any nervous system disorders?	Y N		

_____ Fainting _____ Seizures _____ Anxiety _____ Other _____

Has your child had any history or ever been diagnosed with any of the following (mark all that apply):

_____Anemia	_____Chronic Sinusitis	_____Kidney Problems
_____Allergy/Hay Fever	_____Cleft Lip/Palate	_____Liver Problems
_____Arthritis/Rheumatism	_____COVID	_____Malignant Hyperthermia
_____Artificial Heart Valve	_____Diabetes	_____Measles
_____Artificial Joint/Limb	_____Digestive Problems	_____Mental Deficiency/Disorder
_____Asthma	_____Epilepsy/Seizures	_____Mumps
_____ADD or ADHD	_____Eye Problems	_____Pneumonia
_____Autism	_____Fainting	_____Polio
_____Behavior/Learning Disability	_____Growth Problems	_____Pregnancy
_____Birth Defect	_____Hearing Loss	_____Rheumatic Fever
_____Bleeding Disorder	_____Heart Murmur	_____Scarlet Fever
_____Bone/Joint Problem	_____Heart Problems	_____Scoliosis
_____Brain Injury	_____Heart Surgery	_____Shunt
_____Brain Surgery	_____Hemophilia	_____STD
_____Cancer	_____Hepatitis	_____Tetanus
_____Cerebral Palsy	_____High/Low Blood Pressure	_____Tuberculosis
_____Chemotherapy	_____HIV/AIDS	_____Whooping Cough
_____Chicken Pox	_____Hormonal Disturbances	_____**Other Not Listed Above**

DENTAL HISTORY

Name of previous dentist: _____ Approximate date of child's last dental visit: _____

What was done at this visit? (Cleaning & Exam, Fillings, etc.): _____

How often does your child brush?: _____ How often does your child floss? _____

Has your child...		**Does /Did your child...**	
Had cavities in the past?	Y N	Suck their thumb/pacifier excessively?	Y N
Had any teeth extracted?	Y N	Have anxiety about dental treatment?	Y N
Had orthodontic treatment?	Y N	Consume lots of sugary snacks/drinks?	Y N
Had any injury to teeth/gums?	Y N	Snore or have difficulty nasal breathing?	Y N

Is there anything you would like us to emphasize to your child?: _____

Is there anything else you would like us to know about your child?: _____

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such medical care to health practitioners continuing patient care.

Signature of Legal Guardian: _____Date_____