Sonja G. Norris, DDS
General Dentistry

Personal, Medical & Dental History Profile

Patient's Name _____

Preferred Name _____ Male_____Female_____

Name of person preparing history _____

Relationship to patient _____Date_____

Your careful and complete answers to the following questions will be very helpful in the evaluation of your child's present dental condition.

MEDICAL HISTORY

Complications pre-natally, in birth, or infancy:_____

Place of birth: _____ City_____ State_____

Family physician or pediatrician: _____ City _____ State_____

Has your child ever had any surgeries? If so, give age and experience, good or bad: _____

Family history of malignant hyperthermia? ☐ Yes ☐ No

List any pre-medications required by physician prior to procedures/surgeries:

_____

List all childhood diseases; medical, physical, emotional conditions (give age when occurred):

_____

Current medications: _____ Weight:_____

List any allergies to medications/foods: _____

Check all that apply to your child, past or present, and provide details, where applicable:

Yes	No	
☐	☐	AIDS/Hepatitis _____
☐	☐	Asthma, Hay Fever _____
☐	☐	Autism/ADHD _____
☐	☐	Blood Disorders/Prolonged Bleeding _____
☐	☐	Chemotherapy/Radiation Therapy _____
☐	☐	Diabetes _____
☐	☐	Ear/Sinus Problems_____
☐	☐	Frequent Colds _____
☐	☐	Gagging/Nausea _____
☐	☐	Heart Condition or Disease _____
☐	☐	Kidney/Liver Dysfunction or Disease_____
☐	☐	Methicillin-resistant Staphylococcus aureus (MRSA) _____
☐	☐	Psychological Counseling/Physical Trauma _____
☐	☐	Reflux/GERD _____
☐	☐	Seizures _____
☐	☐	Slow Healing_____
☐	☐	Special Diet(s) /High Caloric/High Protein _____

Female Patients: Date of 1st Menses _____

Does your child become worried or upset when visiting the physician or getting injections? ☐ Yes ☐ No

Describe behavior: _____

_____

MEDICAL HISTORY UPDATED – (Review details in box above)

Parent/Guardian initials:	Date:	Parent/Guardian initials	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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DENTAL HISTORY

Is this the child's first visit to the dentist? ☐ Yes ☐ No

At what age was first visit?_____ Date of last visit?_____

Who brushes the child's teeth? _____

When are child's teeth brushed? _____

Is dental floss used? ☐ Yes ☐ No If yes, how often are teeth flossed? _____

Describe chief oral/dental concern:_____

_____

If treatment is required, would you like your child to be sedated? ☐ Yes ☐ No

Please give details, where applicable:

Yes	No	
☐	☐	Does your child snack frequently throughout the day; i.e., cookies, potato chips, etc? _____
☐	☐	Does your child drink from a sippy cup? Juice/pop? _____
☐	☐	Do child's gums bleed easily? _____
☐	☐	Are child's [ ] teeth or [ ] gums sensitive?_____
☐	☐	Is your water source a private well? If public water source, its name:_____
☐	☐	Is your child receiving fluoride tablets or drops? _____
☐	☐	Has any swelling been noted? _____
☐	☐	Have any teeth been filled, extracted or crowned? _____
☐	☐	Have there been any injuries to teeth via falls, blows, chips, etc? _____
		_____
☐	☐	Does child now, or did s/he ever suck: ☐ thumb ☐ tongue ☐ fingers ☐ other objects?
		Age when stopped _____
☐	☐	Have any measures been taken to reduce the rate of new caries (cavities) such as fluoride rinses,
		fluoride treatment or special diets?_____

Regarding child's past experiences, please note any positive or negative feelings or opinions:

	Positive		Negative	
C=Child P=Parent	C	P	C	P
Dentist:				
Filling teeth:				
Anesthetics:				
X-rays:				
Fluoride Treatment:				
Hygiene/Cleaning Teeth:				

Explain any negative feelings: _____

_____

If any teeth were previously filled or extracted, where did this occur (dental facility):_____

Approximate dates: _____

How was your child numbed or anesthetized?

- Local/Numbed ☐
- IV Sedation ☐
- Oral Sedation ☐
- Nitrous (Laughing Gas) ☐
- General Anesthesia ☐

Negative reactions to any of the above? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

SOCIAL HISTORY

School: _____ Grade:_____ Special/Remedial classes? ☐ Yes ☐ No

Favorite subjects: _____

Do you consider your child to be (please describe):

Advanced in the learning process: _____

Progressing normally in the learning process: _____

Learning at a slower rate than most his/her age: _____

Hobbies, sports, or pastimes: _____

How many siblings does child have?_____Ages?_____

Is child generally considered: ☐ Nervous ☐ Calm ☐ Fearful ☐ Confident ☐ Sensitive ☐ Spoiled ☐ Demanding ☐ Loud ☐ Reserved ☐ Outgoing ☐ Quiet

Summarize general personality and temperament further here, if you feel that you can add to the above information:

_____

_____

I have provided information to the best of my knowledge at this time.

_____ _____

Parent/Guardian Date