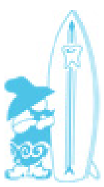

DR. RAYMOND RAMOS AND DR. MARTIN STEIGNER
PEDIATRIC DENTISTRY

3835 Cypress Drive, Suite 210
Petaluma, CA 94954
707-763-1548
Fax 707-763-6942

DENTAL AND HEALTH HISTORY

Patient Name: ______________________________ **Who is your child's medical doctor?** __________________________

MEDICAL HISTORY

Does your child or has your child had any of the following? Please check:

Yes	No		Yes	No	
		Taking any medications: prescription, over-the-counter, or herbal supplements. List:			Heart defect, heart murmur, or any heart problem
		Currently under medical care/treatment			Diabetes: Type
		Immunizations are current			Endocrine system disorders
		Abnormal bleeding, blood disorder, hemophilia, etc.			Epilepsy
		ADD/ADHD			Frequent infections
		AIDS/HIV			Hearing impaired
		Allergy to Aspirin			Hepatitis
		Allergy to Foods			High or low blood pressure
		Allergy to Latex			Hospitalizations
		Allergy to Local anesthetic (ex: Novacaine)			Learning/behavioral disabilities
		Allergy to Metals			Liver problems
		Allergy to Penicillin or other antibiotics			Kidney problems
		Allergy to Sedatives			Premature Birth
		Allergy to Sulfa Drugs			Psychiatric treatment or counseling
		Allergies: Other (please list below)			Pregnancy
		Anemia			Radiation or chemotherapy
		Any operations			Rheumatic fever
		Asthma			Seizures
		Autism/Autism Spectrum Disorder			Sickle cell anemia
		Blood transfusion			Sight disorders
		Breathing/lung problems			Skin problems
		Cancer/tumors			Stomach problems
		Cerebral Palsy			Syndromes
		Cleft lip and/or palate			Tuberculosis (TB)
		Developmental Disability			Other medical condition:

Please describe any yes answers: ____
____
____
____
____

PLEASE COMPLETE THE SECOND PAGE OF THIS FORM

AUTHORIZATION: I certify that I have read and understand the information on this form to the best of my knowledge. The questions on this form have been accurately answered. I authorize the dentist to release information of my diagnosis and treatment records for my child to other health care practitioners or my insurance provider. I authorize the exam, x-rays, and treatments as deemed necessary by the dentist for my child.

Parent Signature: ______________________________ **Relationship:** ________________________ **Date:** ___________

Reviewed by: ____ **Date**: _____________________________________

DENTAL HISTORY

Why did you bring your child to the dentist today? ____

Has/does your child? Please check:

Yes	No	
		Ever seen a dentist before - Previous Dentist Last visit
		Have you been satisfied with their previous dental care
		Had serious/difficult problems with dental treatment – Describe
		Take Fluoride supplements
		Experienced injuries to their teeth, mouth, jaw, falls, chips, etc. - Describe
		Seen an orthodontist - Orthodontist Last visit
		Brush their teeth daily - # of times per day
		Do you help them brush their teeth
		Floss their teeth daily - # of times per day
		Do you help them floss their teeth
		Drink soda - # of times per day
		Drink juice - # of times per day
		Drink milk - Any additives (chocolate, etc.): No Yes:
		Eat candy - # of times per day
		Snack often - # of times per day Type of snacks
		Breast-fed - Discontinued at what age
		Bottle-fed - Discontinued at what age
		Slept/sleeps with the bottle - Discontinued at what age
		Thumb/finger sucking - Discontinued at what age
		Pacifier - Discontinued at what age
		Teeth grinding/clenching
		Speech problems
		TMJ/jaw problems
		Lip biting/sucking
		Nail biting
		Mouth breather
		Frequent mouth sores
		Bleeding gums
		Toothaches – Describe
		Family history of missing or extra teeth or other dental anomalies - Describe
		Family history of dental cavities - Describe

Comments/concerns to bring to our attention:

____
____
____
____

Please list some of your child's interests:

____
____
____
____

THANK YOU