Complete Health Dentistry of Portland

PEDIATRIC ORAL AND SYSTEMIC HEALTH HISTORY

While dentistry is our primary purpose, we believe children want a healthy mouth and a healthy body. Let us partner with them for both.

Patient Name_____ Date of Birth_____

Legal Guardian(s) Name(s)_____Today's Date_____

What is your most important concern today?

Medical Care:

Does your child:

Have Special health care needs?.....**Y N**
Have any active medical conditions or disabilities?... **Y N**
Have a history of complications during pregnancy or infancy..... **Y N**
Avoid any recommended preventive services, including vaccinations?..... **Y N**
Have health goals you are trying to help him/her Achieve?..... **Y N**
Who is their **primary physician**?

Do you wish your child was better cared for or that you were more trusting of your child's medical team?.... **Y N**

Pharmacology:

List all medications your child is currently taking including prescription OTC meds, vitamins and supplements:

Does your child have a history of antibiotic therapy for recurring infection(s)?.....**Y N**

Allergies and/or Food Sensitivities

Are you aware of any allergies?.....**Y N**
If so, to what?

Does your child:
Have identified food sensitivities such as dairy, Wheat, soy or nuts?.....**Y N**
Eat foods that cause him/her to feel sluggish, Hyperactive, or sick?.....**Y N**
Suffer from GI disturbances such as discomfort, Bloating, constipation, or diarrhea?.....**Y N**
Have acid reflux or regurgitation?.....**Y N**
Have red, patchy or itchy skin or ears?.....**Y N**
Get congested frequently?.....**Y N**
Exhibit an unhealthy weight (overweight or Underweight)?.....**Y N**

Exercise and Lifestyle:

Does your child:

Get less-than-daily physical exercise?.....**Y N**
Have more "screen time" than physical play time?... **Y N**
Regularly consume processed foods or fast foods?... **Y N**
Lack of interest in exercise or athletics?..... **Y N**
Have concentration problems when not stimulated by electronics?..... **Y N**

Behavior:

Does your child:

Have difficulties with communication?.....**Y N**
Have ongoing behavior challenges at home or in School?.....**Y N**
Have a diagnosis on the Autism spectrum?.....**Y N**

Dental History:

Does your child have a history of fear, or avoidance behavior at a medical/dental appointment?.....**Y N**

Previous Dentist:

Most recent dental visit: _____
Most recent x-rays: _____
Has your child seen an orthodontist.....**Y N**

Caries Disease (Tooth Decay):

Does your child:

Have primary care-givers with a history of adult decay?.....**Y N**
Snack more than twice a day between meals?.....**Y N**
Snack or drink anything other than water within an hour of bedtime?.....**Y N**
Sleep with a bottle?.....**Y N**
Consume sugary drinks including juice, soda, and/or sports drinks?.....**Y N**
Consume sugary foods such as crackers, breakfast cereals, chewy fruit snacks or candy?.....**Y N**
Have a history of tooth decay or an abscessed tooth?.....**Y N**

Fluoride:

Does your child:

Consume water from:

- ☐ Tap (city) water
- ☐ Filtered tap water
- ☐ Well (county) water
- ☐ Bottled water

Do you know the fluoride content of the water they drink?.....**Y N**

Take fluoride supplements?.....**Y N**

Receive professionally applied topical fluoride?.....**Y N**

Use toothpaste with fluoride? .....**Y N**

Home Care:

Does your child:

Receive daily adult-assisted tooth brushing?.....**Y N**

Have skills to brush independently?..... **Y N**

Receive daily adult-assisted flossing?.....**Y N**

Have skills to floss independently?.....**Y N**

Have professionally applied sealants?.....**Y N**

Sleep and Airway:

Does your child:

Snore or make breathing noises when sleeping? .....**Y N**

Have any history of strep throat, ear infections, or sinusitis?.....**Y N**

Breathe with his/her mouth open? .....**Y N**

Experience bedwetting?.....**Y N**

Grind his/her teeth during sleep?.....**Y N**

Have ADHD-history, behavior disturbances or anxiety attacks?.....**Y N**

Experience any learning difficulties?.....**Y N**

Have oral habits such as finger, thumb or pacifier sucking?.....**Y N**

Have any "screen time" within 30 minutes of bed? .....**Y N**

Dental and Facial Growth and Development:

Does your child:

Breathe through his/her mouth rather than nose?....**Y N**

Have a history of receiving breast milk or formula from a bottle rather than breast?.....**Y N**

Have a history of difficulty with latching?.....**Y N**

Have a tongue-tie or lip-tie?.....**Y N**

Prefer a soft diet over harder-to-chew foods?.....**Y N**

Have any issues with speech or articulation of sounds such as "L" or "S"?.....**Y N**

Function/Bite/TMJ Dysfunction:

Does your child:

Have foods that are difficult to chew? ..... **Y N**

Choke or gag on foods not chewed well?.....**Y N**

Have extra, missing or fused teeth? .....**Y N**

Have clicking, popping or pain in either jaw joint.....**Y N**

Aesthetics:

Does your child:

Are there any cranial, facial, or dental abnormalities that concern you?.....**Y N**

Are there any tooth discolorations that concern you?..... **Y N**

Are there any tooth size or tooth position discrepancies that concern you?.....**Y N**

Tooth Eruption:

Child's age (in months) when first tooth erupted? _____

Has your child experienced teething or eruption problems?.....**Y N**

Injury Prevention and Trauma

Are there areas in your home that are not considered child proof?.....**Y N**

Has your child had an oral/facial injury?..... **Y N**

Does your child play any sports (organized or not)?...**Y N**

If so, what do they play? _____

Is there anything else you would like us to know?

"To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to this child's health. I will inform Complete Health Dentistry of Portland of any changes in their health status".

Legal Guardian: _____

Signature _____Date _____