Amanda N. Siu, D.D.S.

Board Certified Pediatric Dentist

MEDICAL HISTORY

Child's Name: _____ Date of Birth: _____ Today's Date: _____
Child's Physician: _____ Phone: (____) _____ Date of last visit: _____
Address: _____
Is your child currently under the care of a physician? ☐Yes ☐No Please Explain:_____
Was there any complications during pregnancy or the birth of your child? ☐Yes ☐No Please Explain: _____
Was your child born premature (<36 weeks)? ☐Yes ☐No
Was your child born underweight (<5.5lbs)? ☐Yes ☐No
Does your child have social/ personality/ temperament concerns that we should be aware of? ☐Yes ☐No
Please describe your child's current physical health:☐Good ☐Fair ☐Poor Are Immunizations Current?☐Yes ☐No
Please list all medications/vitamins and dosage that your child is currently taking: _____
Please list all drugs and/ or things that cause your child allergic reactions:_____
Anything you would like to discuss with the Doctor in Private?☐Yes☐No

Has your child had/ experienced any of the following: (please check all that apply):

Abnormal Bleeding	☐Y ☐N	Chicken Pox	☐Y ☐N	Heart Murmur	☐Y ☐N	Mononucleosis	☐Y ☐N
AIDS, HIV+	☐Y ☐N	Congenital Birth Defect	☐Y ☐N	Hemophilia	☐Y ☐N	Recurrent Headaches	☐Y ☐N
Allergies	☐Y ☐N	Congential Heart Defect	☐Y ☐N	Hepatitis	☐Y ☐N	Rheumatic Fever	☐Y ☐N
Anemia	☐Y ☐N	Diabetes	☐Y ☐N	High Blood Pressure	☐Y ☐N	Seizures	☐Y ☐N
Any Hospital Stays	☐Y ☐N	Endocrine System Disorders	☐Y ☐N	Hives	☐Y ☐N	Scarlet Fever	☐Y ☐N
Any Operations	☐Y ☐N	Epilepsy	☐Y ☐N	Kidney Problems	☐Y ☐N	Sickle Cell Anemia	☐Y ☐N
Asthma	☐Y ☐N	Frequent Infections	☐Y ☐N	Liver, GI System Problems	☐Y ☐N	Sight Disorders	☐Y ☐N
Blood Dyscrasis	☐Y ☐N	Hadicaps	☐Y ☐N	Low Blood Pressure	☐Y ☐N	Significant Injuries	☐Y ☐N
Blood Transfusion	☐Y ☐N	Behavior, Learning, Disabilities	☐Y ☐N	Lupus	☐Y ☐N	Skin Rash	☐Y ☐N
Breathing, Lung Problems	☐Y ☐N	Mentally, Physically Disabled	☐Y ☐N	Measles	☐Y ☐N	Tonsilitis	☐Y ☐N
Cancer, Tumors	☐Y ☐N	Hearing Impaired	☐Y ☐N	Mitral Valve Prolapse	☐Y ☐N	Tuberculosis (TB)	☐Y ☐N

Please elaborate on any medical problems discussed above or describe any medical problems your child experiences(d) not listed above: _____

_____

DENTAL HISTORY

Is your child currently in pain? ☐ Yes ☐ No
Is this your child's first dental visit? ☐ Yes ☐ No
Previous Dentist: _____ Date of Last Visit: _____ Date of Last X-rays: _____
Why did you leave your previous dentist:_____
What did you like most about any dentist you have seen? _____ Least? _____
Has your child had any negative dental experiences?☐Yes ☐No If so, please explain:_____
Have there been any injuries to the teeth, mouth, head or neck? ☐ Yes ☐ No
Does your child take fluoride vitamins or drink fluoridated water? ☐ Yes ☑ No
Has your child been seen by an orthodontist? ☐ Yes ☐ No Who?:_____
Does your child brush daily? ☐Yes ☐No Receive help? ☐ Yes ☐ No
Does your child floss daily? ☐Yes ☐No Receive help? ☐ Yes ☐ No
Does your child have any of the following habits?
☐TMJ/TMD Pain ☐Clenching/ Grinding Teeth ☐Thumb/ Finger Sucking/Pacifier ☐Speech Problems ☐Bottle use

I certify that the information I have given is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my/my child's health. It is my responsibility to inform the dental office of any changes in my/my child's medical status. I will not hold the dentist or any member of the staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form
Patient / Guardian Printed Name: _____ Patient / Guardian Signature: _____ Date: _____