BASKING RIDGE PEDIATRIC DENTISTRY
MEDICAL AND DENTAL HISTORY

Child's name:_____
Primary physician:_____Address/phone:_____Last visit: _____
Medical specialists:_____Address/phone:_____Last visit: _____

Is your child currently on any medications? ..... □ Y □ N Explain _____
Does your child have any serious or chronic illnesses? □ Y □ N Explain _____
Has your child had any serious injuries or accidents? □ Y □ N Explain _____
Has your child had any surgeries? ..... □ Y □ N Explain _____
Has your child ever been hospitalized? ..... □ Y □ N Explain _____
Is your child allergic to any medications? ..... □ Y □ N Explain _____
Does your child have any food allergies? ..... □ Y □ N Explain _____
Is your child allergic to latex? ..... □ Y □ N Explain _____

Please mark YES if your child has a history of the following conditions. Please provide details if YES.

Heart murmur, congenital heart defect/disease,
rheumatic fever or heart surgery ..... □ Y □ N Explain _____
Irregular heartbeat or high blood pressure ..... □ Y □ N Explain _____
Asthma, reactive airway disease, breathing disease .. □ Y □ N Explain _____
Cystic Fibrosis ..... □ Y □ N Explain _____
Liver or problems, hepatitis ..... □ Y □ N Explain _____
Gastroesophageal/acid reflux disease (GERD) ..... □ Y □ N Explain _____
Kidney or bladder problems ..... □ Y □ N Explain _____
Eczema or skin problems ..... □ Y □ N Explain _____
Anemia or bleeding problem ..... □ Y □ N Explain _____
Cancer, tumor ..... □ Y □ N Explain _____
Sleep apnea, snoring, mouth breathing ..... □ Y □ N Explain _____
Diabetes ..... □ Y □ N Explain _____
Thyroid or other gland problem ..... □ Y □ N Explain _____
Autism/Autism spectrum disorder ..... □ Y □ N Explain _____
Mental Health Issues ..... □ Y □ N Explain _____
ADD/ADHD ..... □ Y □ N Explain _____
Developmental disorders/learning problems ..... □ Y □ N Explain _____
Hydrocephaly or placement of a shunt ..... □ Y □ N Explain _____
Cerebral Palsy ..... □ Y □ N Explain _____
Seizures ..... □ Y □ N Explain _____
Problems with eyes or vision ..... □ Y □ N Explain _____
HIV/AIDS ..... □ Y □ N Explain _____
Females: Do you take birth control pills? ..... □ Y □ N Explain _____
Other medical history ..... □ Y □ N Explain _____

BASKING RIDGE PEDIATRIC DENTISTRY
DENTAL HISTORY

Child's Name _____
Is this your child's first visit to the dentist? □ Y □ N
If no, former dentist _____
Address/Phone_____
Date of last dental visit _____
Date of last x-ray _____

How many times a day is your child brushing? _____ Does someone help your child brush? □ Y □ N
How many times does your child floss? _____ Does someone help your child floss? □ Y □ N
What type of toothbrush does your child use? _____
What toothpaste does your child use? _____

What is the source of your drinking water at home? □ City □ Well □ Bottled Water
Please check all the sources of fluoride your child receives:
□ Drinking Water □ Toothpaste □ OTC rinse □ Prescription toothpaste/gel
□ Prescription drop/tablets/vitamins □ Fluoride varnish by pediatrician □ Other: _____

Does your child have any speech problems? ..... □ Y □ N Explain _____
Does your child have any habits of:
□ Thumbsucking □ Pacifier □ Nail biting □ Grinding □ Lip sucking
Explain _____

Does your child have any TMJ pain? ..... □ Y □ N Explain_____

SUPPLEMENTAL HISTORY QUESTIONS FOR INFANTS/TODDLERS

Was your child born prematurely? ..... □ Y □ N Explain_____

How long was your child bottle-fed? _____
Does/Did your child sleep with the bottle? ..... □ Y □ N
If yes, what was in the bottle? _____
Does/Did your child use a sippy cup? ..... □ Y □ N
Does/Did your child use a pacifier? ..... □ Y □ N ..... Until what age? _____
Do/Did you breastfeed? ..... □ Y □ N ..... Until what age? _____
Do/Did you have any issues with breastfeeding? ..... □ Y □ N Explain_____

When did you begin brushing his/her teeth? _____
When did you begin using toothpaste? _____

Child's age when the first tooth appeared in the mouth _____

_____ _____ _____
Signature of parent or guardian Relationship to child Date