Port Warwick DENTAL ARTS
COMPREHENSIVE DENTISTRY FOR TOTAL WELLNESS, FUNCTION AND BEAUTY

Pediatric Oral and Systemic Health History

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

Child's Name_____ Nickname_____ Date of Birth_____ Age_____

Parent or Legal Guardian's Name_____ Relationship_____

Signature_____ Today's Date_____

What is your most important concern and what would you like to accomplish today?

Has your child ever had any ill effects from dental treatment? Y N Describe_____

Medical Care:

Does your child:

Have special healthcare needs?	Y	N
Have any active medical conditions or disabilities? If yes, please list:	Y	N
Have a history of complications prenatally or in infancy?	Y	N
Have you avoided any recommended preventive services, including vaccinations?	Y	N
Have health goals you are trying to help him/her achieve?	Y	N
Who is your child's 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 and OTC meds, vitamins and supplements:

Does your child have a history of antibiotic therapy for recurring infections?	Y	N

Allergy and/or Food Sensitivities:

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

Does your child

Have identified food sensitivities such as dairy, gluten, soy, or nuts? *(circle)*	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 frequent vomiting?	Y	N
Have red, patchy or itchy skin or itchy ears?	Y	N
Get congested frequently?	Y	N
Exhibit an unhealthy weight: overweight or underweight? *(circle)*	Y	N

Exercise and Lifestyle:

Does your child:

Get less than daily physical exercise?	Y	N
Have more screen-time than physical play?	Y	N
Regularly consume processed foods or fast foods?	Y	N
Lack 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, anxiety, or avoidance behavior during a medical/dental appointment?	Y	N

Previous Dentist:

Most recent dental visit:

Most recent x-rays:

Does your child clench or grind his/her teeth?	Y	N
Has your child seen an orthodontist?	Y	N

Caries Disease (Tooth Decay) and Periodontal (Gum) Disease:

Does your child:

Have primary caregivers with a history of decay?	Y	N
Have primary caregivers with a history of gum disease?	Y	N
Snack more than twice a day in-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	Y	N
filtered tap water	Y	N
well (country) water	Y	N
bottled water	Y	N

Take fluoride supplements?	Y	N
Use toothpaste with fluoride?	Y	N

How do you feel about fluoride?

Ozone Therapy:

Are you familiar with the benefit of medical ozone in preventing and treating early decay?	Y	N

Home Care:

Does your child:

Receive daily adult-assisted tooth brushing?	Y	N
Have skills to brush independently?	Y	N
Receive daily assisted flossing or toothpicking?	Y	N
Have skills to floss or pick independently?	Y	N
Have professionally applied sealants?	Y	N

Sleep and Airways:

Does your child:

Snore or make breathing noises when sleeping?	Y	N
Have any history of strep throat, ear infections, environmental allergies or sinusitis? *(circle)*	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 2 hours of bedtime?	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 latching to the breast?	Y	N
Have a diagnosis of a tongue-tie or a 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” or “R”?	Y	N

Function / Bite / TMJ Dysfunction:

Does your child:

Have difficulty with tooth eruption?	Y	N
Choke or gag on foods?	Y	N
Have difficulty chewing certain foods?	Y	N
Have a diagnosis of extra, missing or fused teeth?	Y	N

Aesthetics:

Are there any head, neck, 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?	Y	N
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 any oral/facial injury?	Y	N

Does your child have favorite people, activities or possessions?

Is there anything else you would like us to know about your child?