Alameda Pediatric Dentistry - Eaglesoft Medical History

Alameda (510) 521-5437 • Pleasanton (925) 846-5437 • Oakland (510) 763-5437

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
Does your child have any health concerns?	☐ Yes ☐ No	If yes
Has your child ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes
Have you declined any recommended immunizations (vaccinations) for your child?	☐ Yes ☐ No	If yes
Is your child sensitive or allergic to any drug(s), food(s), or latex products?	☐ Yes ☐ No	If yes
Is your child taking any drug(s) or medicine	☐ Yes ☐ No	If yes

Does your child have or had a history of:

☐ asthma	☐ heart murmur	☐ speech impediment	☐ liver disease
☐ emotional problems	☐ heart condition	☐ rashes, eczema, or skin problems	☐ kidney disease
☐ autism/autism spectrum disorder	☐ seizures	☐ hearing difficulty	☐ hemophilia
☐ attention deficit disorder	☐ diabetes	☐ cerebral condition	☐ excessive gagging
☐ mental disturbance			

Does your child have any other special healthcare needs? ☐ Yes ☐ No If yes

Question	Answer	
Has your child been examined by another dentist? (If yes, please indicate date of last visit)	☐ Yes ☐ No	If yes
Does your child take any fluoride supplements?	☐ Yes ☐ No	If yes
Is or was your child on an enhanced formula?	☐ Yes ☐ No	If yes
Does your child drink liquids other than water from a bottle/sippy cup?	☐ Yes ☐ No	If yes
How do you think your child will react to dental treatment?		
How often does your child brush his/her teeth?		
What toothpaste does your child use?		

Additional comments:

Would you like us to inform your child's physician of our dental findings? ☐ Yes ☐ No

Name of physician:

Physician's address:

Physician's phone number:

Medical record number:

Print name of responsible party signing this form: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature ____ Date: ____________________________