ALAMEDA
Pediatric Dentistry
& Orthodontics

HEALTH INFORMATION Ages 0-5 years

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

DENTAL HISTORY

Is/was your child breast-fed and/or bottle-fed? (Please circle) | Until age: _____

Does your child take any enhanced formula or fluoride supplements? Yes ☐ No ☐ Describe: _____

Does your child drink juices/sweetened drinks? Yes ☐ No ☐ If yes, what kind: _____

On average, how many times per day does your child snack in between meals? _____

How often does your child brush their teeth? _____ What toothpaste do they use? _____

Does your child floss daily? Yes ☐ No ☐ Does an adult assist with the brushing and/or flossing? Yes ☐ No ☐

How do you think your child will react to dental treatment? _____

Has your child had any injuries to teeth, mouth, face, or head? If yes, please describe: _____

Does your child have any of the following habits? If yes, please check **P**ast or **C**urrent:

	P/C		P/C		P/C		P/C		P/C
Pacifier	☐ ☐	Cheek Biting	☐ ☐	Lip Sucking	☐ ☐	Jaw Clenching	☐ ☐	Snoring	☐ ☐
Thumb Sucking	☐ ☐	Nail Biting	☐ ☐	Tongue Thrust	☐ ☐	Mouth Breathing	☐ ☐	Grinding	☐ ☐

Is there clicking, popping, or discomfort in the jaw joints? Yes ☐ No ☐ If yes, when did it begin: _____

MEDICAL HISTORY

Current Age: _____ Height: _____ Weight: _____ Pronouns: _____

Is your child taking any medications or drugs? Yes ☐ No ☐ If yes, list: _____

Is your child sensitive or allergic to any drug(s), food(s), latex products, or other materials? Yes ☐ No ☐

If yes, describe: _____

Has your child ever been hospitalized or had a major operation? Yes ☐ No ☐ If yes, describe: _____

Are your child's immunizations up to date? Yes ☐ No ☐ If no, reason: _____

Child's Pediatrician: _____ Date of Last Visit: _____

Pediatrician Location/Address: _____ Phone #: _____

MEDICAL HISTORY

Has your child ever been diagnosed as having any of the following? If yes, please select:

- ☐ ADD and/or ADHD
- ☐ AIDS and/or HIV+
- ☐ Artificial Joints or Limbs
- ☐ Asthma / Breathing Problems
- ☐ Autism Spectrum Disorder
- ☐ Bone Conditions
- ☐ Blood Disorders
- ☐ Cancer or Malignancies
- ☐ Cerebral Conditions
- ☐ Chemotherapy / Radiation
- ☐ Chronic Adenoid/Tonsil Infection
- ☐ Chronic Ear Infections
- ☐ Chronic Headaches or Migraines
- ☐ Cleft Lip / Palate
- ☐ Congenital Disorders
- ☐ Currently Pregnant
- ☐ Cystic Fibrosis
- ☐ Developmental Delay
- ☐ Diabetes Type 1 or Type 2
- ☐ Eating Disorders
- ☐ Emotional Problems
- ☐ Endocrine Conditions
- ☐ Epilepsy or Seizures
- ☐ Excessive Gagging
- ☐ Frequent Infections
- ☐ Gastrointestinal Issues
- ☐ Hearing Impaired
- ☐ Heart Conditions
- ☐ Hepatitis
- ☐ High / Low Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Nutritional Deficiency
- ☐ Oral Ulcers
- ☐ Premature Birth
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Skin Problems
- ☐ Sleep Apnea
- ☐ Speech Impediment
- ☐ TMJ Disorder
- ☐ Tuberculosis

Any Other Dental or Health Concerns: _____

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

Parent/Guardian Name (Print): _____ Signature: _____

CLINICAL USE ONLY Reviewed by: _____