PEDIATRIC DENTAL SPECIALISTS, PLLC
INITIAL ORAL ASSESSMENT

Patient Name: _____ **Date:** _____
Patient/ Guardian name? _____
Reason for today's visit: _____

Medical History

1. Does your child have any **illnesses?** **YES / NO**
   If yes, please explain. _____
2. Has your child ever been **hospitalized?** **YES / NO**
   If yes, please explain. _____
3. Has your child had any **surgeries**? **YES / NO**
   If yes, please explain. _____
4. Date of last physical and regular **doctor's name?** _____
5. Are your child's **immunizations** up-to-date? **YES / NO**
6. Is there any significant **family medical history?** **YES / NO**
7. Are there any problems in the family with **general anesthesia?** **YES / NO**
   If yes, please explain. _____
8. Is your child taking any **medications** (prescription or OTC)? **YES / NO**
   If yes, please explain. _____
9. Does your child have any **allergies** to any foods or medications? **YES / NO**
   If yes, please explain. _____
10. Is your child exposed to **smoke?** **YES / NO**

Dental History

11. Is this your child's **first dental visit?** **YES / NO**
    If no, date of last visit and treatment. _____
12. Has your child had any **bad experiences** at the dental office before? **YES / NO**
    If yes, please explain. _____
13. How does your child react to **dental treatment?** **WELL** **ACCEPTIBLE** **FEARFUL/RESISTANT**
14. Has your child had any **injuries** to the face or teeth? **YES / NO**
    If yes, please explain. _____
15. Does your child have any **oral habits,** like sucking on objects or fingers? **YES / NO**
    If yes, please explain. _____
16. Is there **fluoride** in your drinking water? **YES / NO/ NOT SURE**
17. What **snacks** does your child eat most often? _____
18. Does your child take a **drink** to bed? **YES / NO**
    If yes, please explain. _____
19. Does your child have unrestricted access to **drinks** in a cup or bottle during the day? **YES / NO**
    If yes, please explain. _____
20. Does your child have a history of bad reactions to **local anesthetic?** **YES/ NO**
    If yes, please explain. _____

Does your child currently have or has had a history of any of the following: YES / NO

AIDS-HIV
Anemia
Arthritis
Asthma
Autism
Birth Control
Birth Defects
Bladder Problems
Bleeding Problems
Blood Disease
Blood Transfusion
Bone Problems
Bone Marrow Transplant
Brain Injury
Bruising Easily
Cancer
Cerebral Palsy
Chemotherapy/Radiation
Chicken Pox
Chronic Ear Infections
Cleft Lip/Palate
Cystic Fibrosis
Developmental Delay
Diabetes
Disease Affecting Normal Growth
Drug Addiction
Ear Stuffiness, Itching, Noises
Eating Disorders
Eczema
Emotional Difficulties
Epilepsy, Seizures or Convulsions
Eye Problems
Excessive Gagging
Fainting or Dizziness
Fever Blisters
Frequent Coughs/ Colds
Genetic Disorders
Growth and Development Problems
Headaches
Hearing or Speech problems
Heart Defect
Heart Murmur
Heart Surgery
Hemophilia
Hepatitis A
Hepatitis B
Hepatitis C
High Blood Pressure
Hydrocephaly
Hyperactivity/ADHD
Kidney Disease
Leukemia
Liver Disease
Loud Snoring
Measles/Mumps/Rubella
Mouth Breathing
Nutritional Deficiency
Oral Ulcers
Pain in Joints
Premature Birth
Problems with Anesthesia
Psychiatric Care
Reflux Disease
Rheumatic Fever
Scoliosis
Second- Hand Smoke Exposure
Sexually Transmitted Disease
Shunt Placement
Sickle Cell Anemia
Skin Problems
Stroke
Syndrome
Tonsil Problems
Tuberculosis
Whooping Cough

Currently being followed by a physician for any of the above? YES / NO

Name of physician and phone number: _____

Any other conditions not listed? _____

Parent /Guardian signature:_____ **Date:** _____