

# Medical History Update

Patient Name: \_\_\_\_\_

Child's Physician's Name: \_\_\_\_\_ City: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Preferred Pharmacy Information: \_\_\_\_\_ City: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

## Has your child had or currently have any of the following conditions?

	Yes	No		Yes	No		Yes	No			
Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints (Hip, Knee)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Mental, Emotional, or Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>

Has your child ever had surgery?  Yes  No If yes, list all past surgical procedures. \_\_\_\_\_

Does your child have any disease, problem, or condition not listed?  Yes  No If Yes, what? \_\_\_\_\_

Has your child been under the care of a Physician in the last 2 years?  Yes  No

Is your child currently under the care of a Physician?  Yes  No If Yes, why? \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No If Yes, why? \_\_\_\_\_

Is your child currently taking any medication, drugs, pills, or vitamins?  Yes  No If Yes, what? Please list below:


Does your child have an allergy to local anesthetic?  Yes  No If Yes, what? \_\_\_\_\_

Does your child have an allergy to any other medication(s)?  Yes  No If Yes, what? \_\_\_\_\_

Does your child have an allergy to latex / rubber products/ metals?  Yes  No If Yes, what? \_\_\_\_\_

Has your child ever had a prescription for Bisphosphonate (Fosmax)?  Yes  No

Does your child use tobacco products (including vaping devices)?  Yes  No

**FOR FEMALE ONLY:** Is your daughter pregnant?  Yes  No Is your daughter taking Birth Control Pills?  Yes  No

Nearest Relative not living with you: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**THE ABOVE INFORMATION IS TRUE:** To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medication, I will inform the Doctor at the next appointment. If deemed advisable, I grant permission for my Physician to be contracted for details and advice.

X \_\_\_\_\_  
Patient or Guardian Signature

X \_\_\_\_\_  
Provider (Dentist/Hygienist) Signature

\_\_\_\_\_  
Date

**(For Office Use Only) Medical History Review:** I have reviewed this medical history and have added any changes since my last review.

Initial: _____	Date: _____
Dr. Initial: _____	

Initial: _____	Date: _____
Dr. Initial: _____	

Initial: _____	Date: _____
Dr. Initial: _____	

**OVER →**



# Pediatric Risk Assessment Sleep Disordered Breathing & Airway Obstruction

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General & Cosmetic Dentistry

The latest biomedical research is uncovering the link between sleep-related breathing disorders (SRBD) and our overall health. The American Dental Association (ADA) Council on Dental Practice made a Policy Statement emphasizing the important role dental professionals play in screening and either treating or referring for sleep, breathing and airway related disorders. **In compliance with ADA’s position statement, we are providing this screening questionnaire to our patients.**

### Did you know that:

- Obstructive Sleep Apnea may reduce a child’s IQ for the rest of their life.
- Airway obstruction is linked to ADHD, learning disabilities, behavior issues, anxiety, aggression, allergies, asthma, and chronic inflammation.

### Does your child: (check all that apply)

Yes= 1 point, No= 0 points

- Snore while sleeping?
- Mouth-breathe while awake or sleeping?
- Breathe audibly/noisily while awake or sleeping?
- Ever gasp or wake with a startle?
- Appear to stop breathing when sleeping?
- Have nightmares?
- Wet the bed?
- Grind their teeth at night?
- Sleep in odd positions or with their head extended back?
- Toss, turn, thrash, or seem restless during sleep?
- Wake frequently in the night?
- Experience chronic nasal discharge/runny nose or congestion?
- Have recurrent ear infections?
- Appear tired during the day?
- Show visible dark circles under their eyes?
- Struggle with performance in school or have a lack of focus?
- Wake up with a headache?
- Suck their thumb, finger(s), or use a pacifier?
- Exhibit behaviors such as ADD/ADHD tendencies, oppositional/defiant behaviors, tantrums, anxiety, or depression?

### Scoring:

- 0-2: Low suspicion of Sleep Disordered Breathing/Airway Obstruction
- 3-4: Moderate suspicion of Sleep Disordered Breathing/Airway Obstruction
- 5+: High suspicion of Sleep Disordered Breathing/Airway Obstruction

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(For Office Use Only) I have reviewed this medical history and have added any changes since my last review.**

<b>Initial:</b> _____	<b>Date:</b> _____
<b>Dr. Initial:</b> _____	

<b>Initial:</b> _____	<b>Date:</b> _____
<b>Dr. Initial:</b> _____	

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