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

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_____ X_____ _____

Patient or Guardian Signature | 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: _____	Initial: _____ Date: _____	Initial: _____ Date: _____
Dr./Hygienist Initial: _____	Dr./Hygienist Initial: _____	Dr./Hygienist Initial: _____

OVER →

Pediatric Risk Assessment
Sleep Disordered Breathing & Airway Obstruction

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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.

Initial: _____ Date: _____	Initial: _____ Date: _____	Initial: _____ Date: _____
Dr./Hygienist Initial: _____	Dr./Hygienist Initial: _____	Dr./Hygienist Initial: _____