Lehigh Valley Pediatric Dentistry
Medical History Information

Today's Date _____

Child's Name _____ Age_____ □ Male □ Female
Last First
Child's Birthdate _____ Height _____ Weight_____

School _____ Grade _____

Nickname_____ Hobbies _____

Address _____
City State Zip Code
Home Phone # _____ Cell/Pager # _____

Pediatrician _____
Name Address Phone

Whom may we thank for this referral / How did you hear about us? _____
_____

Mother's information:

Name _____DOB: _____

Address_____

Employer_____

Occupation _____

Business Phone _____

Home Phone_____

Cell Phone _____

Father's information:

Name _____ DOB_____

Address_____

Employer_____

Occupation _____

Business Phone _____

Home Phone_____

Cell Phone _____

General Health Status: □ Excellent □ Good □ Fair

Date and reason for child's last medical exam_____

Has your child ever been hospitalized? Yes / No
Reason_____

Is your child allergic to any medicine, food, or substance? Yes / No
List_____

Is your child taking any medications? Yes / No
List_____

Has your child ever had any of the following - please check all that apply:

__Heart Murmur	__Asthma	__Chronic Sinusitis	__Lung Disease
__Heart Disease	__Anemia	__Cerebral Palsy	__Seizures
__Hepatitis	__Bronchitis	__Bleeding Problems	__Epilepsy
__Diabetes	__Tuberculosis	__Blood Transfusion	__Other
__HIV (+) or AIDS	__Thyroid	__Hearing Difficulty	_____
__Kidney disease	__Hemophilia	__Liver Disease	

Has your child's physical development been normal? Yes / No
If no, please explain_____

Does your child have any Psychological/Emotional/Behavioral concerns? Yes / No
If yes, please explain_____

Has your child ever been diagnosed with the following: ADD__ PDD__ ADHD__ Autism__ None __

Is this your child's first visit to the dentist? Yes / No

Name, and date of last visit at previous dentist? _____

Reason for that visit?_____ Were X-rays taken? Yes / No

Does your child have any oral habits? Please check all that apply:

___ Pacifier ___Finger/thumb habit ___Nail biting ___Tongue thrust

___Grinding teeth ___Other _____

Are you happy with the appearance of your child's teeth? Yes / No
If "No" please explain:_____

Does your child take fluoride in any form? Yes / No
List _____

I have answered all questions truthfully and to the best of my knowledge.
Parent / Guardian Signature _____