Phuoc Tran, DDS
Alexandra Shehata, DDS
Arlene Esche, DDS
Pedodontist

Pediatric Medical History

Physician's Name/Phone Number: _____ Date of last exam: _____

Is child currently taking any medications? □ **Yes** □ **No** If yes, what?: _____

Has child ever been hospitalized or a major operation □ **Yes** □ **No** If yes: _____

Woman/Girl Pregnant or Possibly Pregnant? □ **Yes** □ **No** If yes: _____

Has child ever been to another dentist? Were x-rays taken? □ **Yes** □ **No** _____

Has the child had a bad experience at a dental visit? □ **Yes** □ **No** If yes: _____

Has your child had any dental/face injuries? □ **Yes** □ **No** If yes: _____

Allergies to Aspirin/Codeine/Sulfa or Other drugs? □ **Yes** □ **No** If yes: _____

Do you brush your child's teeth? Includes Fluoride? □ **Yes** □ **No** If yes: _____

Are you interested in Invisalign for your child? □ **Yes** □ **No**

Do you have, or have you had any of the following?

AID/HIV Positive	□ Yes □ No	Asthma	□ Yes □ No	Cerebral Palsy	□ Yes □ No
Diabetes	□ Yes □ No	Lung Disease	□ Yes □ No	Autism	□ Yes □ No
Heart Problems	□ Yes □ No	Cancer	□ Yes □ No	Chemotherapy	□ Yes □ No
Rheumatism	□ Yes □ No	Downs Syndrome	□ Yes □ No	Psychiatric Care	□ Yes □ No
Sinus Trouble	□ Yes □ No	Epilepsy/Seizures	□ Yes □ No	ADD/ADHD	□ Yes □ No
Thyroid Disease	□ Yes □ No	Liver Disease	□ Yes □ No	Hepatitis A, B or C	□ Yes □ No
Cold Sores/ Fever Blisters	□ Yes □ No	Tuberculosis	□ Yes □ No	Kidney Problems	□ Yes □ No
High Blood Pressure	□ Yes □ No	Convulsions	□ Yes □ No	Latex Allergy	□ Yes □ No
Ulcers	□ Yes □ No	Bladder Problems	□ Yes □ No	Nut Allergy	□ Yes □ No
Use of a Pacifier	□ Yes □ No	Thumb Sucking	□ Yes □ No	Problems with Anesthetic	□ Yes □ No
Sleep Apnea/Snoring	□ Yes □ No				

Has the child had any other serious illness not listed above? If yes, what?

What are the most important factors you desire from your dental office?

Responsible Party Signature: _____ Date: _____