CM Vera DMD
MW Panagiotu DDS
41 Lancaster Street, Worcester, MA 01609
508-754-9825

Child Health History

Name of Child____ DOB___________

1) Was your child premature? Yes No

2) Were there any difficulties during the pregnancy, delivery or first year of life? Yes No

Explain____

3) Is a physician treating your child now for a specific illness? Yes No

Explain____

4)Is your child taking any medications at this time?

DRUG	FREQUENCY	DOSE	REASON

5)Has your child taken any medication in the past? Yes No

Explain____

6)Has your child any allergies or unusual reactions to the following?

a)Medications Yes No Foods Yes No Latex Yes No

b)Other Yes No

Explain____

7)Has your child ever been hospitalized? Yes No

Explain____

8)Has your child ever had an operation? Yes No

Explain____

a)Was general anesthesia used? Yes No

b)Any complications? Yes No

Explain____

9)Are your child's immunizations up-to-date? Yes No

10)Has your child ever been diagnosed with any of the following conditions? Please check yes or no.

Y N
Anemia
Asthma
Autism
Blood Transfusions
Birth Defects
Bone or joint problems
Brain Injury
Bruising Easily
Cancer or malignancies
Cerebral Palsy
Child Abuse
Chronic Adenoid/tonsil
Chronic Headaches
Chronic Ear Infections
Cleft lip/palate

Y N
Congenital Heart Disease
Convulsions/Seizure
Diabetes
Epilepsy
Eye Problems
Excessive Bleeding Problems
Excessive Gagging
Fainting or Dizziness
Growth/Dev. Problems
Hearing/Speech Problems
HIV
Heart Murmur
Hemophilia
Hepatitis or liver disease
Hyperactivity

Y N
Kidney Disease
Leukemia
Mental Retardation
Oral Ulcers
Orthopedic Problems
Premature Birth
Rheumatic Fever
Scoliosis
Sickle Cell Anemia
Syndrome
Tuberculosis
Other

____

Signature Legal Guardian Print Name Date

____

Doctor/Date

CM Vera DMD, MPH
MWPanagiotu DDS
41 Lancaster Street
Worcester, MA01609
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DENTAL HEALTH:

1) Why did you bring your child to the dentist today? ____

2) How long has it been since your child's last dental exam? ________ last tooth cleaning?_______
First visit ever?_____________________

3) For most drinking & cooking do you use: ❑town water ❑well-water ❑bottled water
If well of bottled, has the water been tested for fluoride? ❑No ❑Yes
Results? ____

4) Does your child take fluoride supplements? ❑Yes ❑ No
Dose____Frequency______________

5) Have there been any injuries to the face, mouth, or teeth? ..❑Yes ❑ No
Please give dates and descriptions____

6) Has your child ever sucked a thumb or fingers? ❑Yes ❑ No
Pacifier?......❑Yes ❑ No
Any other habits?_______________ For thumb, pacifier or other habits until what age?________

7) Does your child have:

Y N		Y N		Y N	
	Snoring		Tooth Grinding		History Of Sleep Apnea
	Daytime Mouthbreathing		Bedwetting Now		Restless Sleep
	Nighttime Mouthbreathing		Hearing Deficiency		Speech Problems
	Frequent Middle Ear Infections				Environmental Allergies

8) Have you been informed of any missing or extra permanent teeth? ❑Yes ❑ No

9) Are there any unusual sounds in ear (clicking) during eating? ❑Yes ❑ No

10) Has your child ever had an orthodontic examination or orthodontic treatment? ❑Yes ❑ No

11) Does your child go to sleep with a bottle, with a sippy cup, or while nursing? ❑Yes ❑ No
Until what age?____

12) Is your child nervous or frightened during dental visits? If yes, please tick
Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous

13) It would be helpful if you would indicate below what things you are looking for most in choosing a pediatric dentist.
____

14) Has your child had any unfavorable medical or dental experience? ❑Yes ❑No
If so, please explain____

____
Signature Legal Guardian Print Name Date

____
Doctor/Date