LOMA LINDA UNIVERSITY CENTER FOR DENTISTRY AND ORTHODONTICS
PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Birth date:_____ Age: _____ Weight:_____ Today's Date:_____

1. Does the child have any of the following diseases or problems (active tuberculosis, persistent cough, cough producing blood, exposed to tuberculosis)?..... ☐Yes ☐No

2. Are there any health conditions that necessitate the child taking medication prior to dental treatment? ..... ☐ Yes ☐ No

3. Is the child now, or has the child been in the past year, under the care of a physician? ..... ☐ Yes ☐ No

4. Has there been any change in the child's general health within the past year?..... ☐Yes ☐ No

5. Has the child had any serious illness, operation, emergency room visit or been hospitalized?... ☐ Yes ☐ No
   If yes, how long ago?_____
   Specify illness or problem:_____

6. Are your child's immunizations up to date?..... ☐ Yes ☐ No

7. Does the child use or has the child used tobacco (smoking, snuff, chew, bidis)?..... ☐ Yes ☐ No

8. Does the child use or has the child used prescription or street drugs or other substances for recreational purposes? ..... ☐ Yes ☐ No

9. FEMALES ONLY: Is the child pregnant? ..... ☐ Yes ☐ No

10. Is the child taking, has the child recently (within the last month) taken, or is the child supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural, or herbal)? ..... ☐ Yes ☐ No

11. Does your child have any history of allergic reactions?..... ☐ Yes ☐ No

Does the child have or has the child had any of the following diseases, problems, or symptoms:

a. Blood/Hematologic disorder?..... ☐ Yes ☐ No

b. Cancer or Tumors?..... ☐ Yes ☐ No

c. Dermatologic/Skin problem? ..... ☐ Yes ☐ No

d. Diabetes/Endocrine disorder..... ☐ Yes ☐ No

e. Eating disorder?..... ☐ Yes ☐ No

f. Growth/Development problem? ..... ☐ Yes ☐ No

g. Head/Eye/Ear/Nose/Throat problem? ☐ Yes ☐ No

h. Heart/Blood Pressure problem? ☐ Yes ☐ No

i. Illnesses/Infectious disease? ☐ Yes ☐ No

j. Kidney/Urinary disorder? ☐ Yes ☐ No

k. Muscle/Bone/Connective Tissue disorder? ☐ Yes ☐ No

l. Neurologic/Nerve problem? ☐ Yes ☐ No

m. Respiratory/Lung problem? ☐ Yes ☐ No

n. Stomach/Intestine/Liver disorder? ☐ Yes ☐ No

12. Does your child have any other medical or dental problems not mentioned here or any additional information that may affect your child's treatment? ☐ Yes ☐ No
If yes, please explain:

_____

My signature below indicates that I understand and have answered all of the above questions to the best of my knowledge. I request and freely consent for my child to have a complete clinical examination and to the performance of any additional tests or procedures, which are deemed necessary after the examination in order to determine my child's dental treatment needs. I have been informed that these procedures will be discussed with me prior to them being done.

_____ _____

Date **Patient, Parent or Guardian Signature**