Dr.Dixon's San Diego Pediatric Dental and Orthodontic Groups
5627 Oberlin Drive Suite 100, San Diego, CA 92121
(858) 452-7272 www.DrDixon.com

HEALTH HISTORY

Date: _____ Update: _____

PERSONAL

Child's Full Name_____ Age _____Birthdate _____
Nickname (if any) _____ Sex_____ Place of Birth _____
What is your child most interested in? _____
Brothers, names and ages?_____ Sisters _____
Is your child adopted? ○Yes ○No If yes, does your child know? ○Yes ○No
Child's pediatrician or physician_____ Telephone #_____
Family Dentist _____ Child attends what school?_____

MEDICAL

Has your child had any of the following medical problems? *Click or Circle Yes (Y) or No (N).*

Allergies to drugs or food	○Yes ○No	Ear infections	○Yes ○No	Hospital stays or operations	○Yes ○No
Allergies to Latex	○Yes ○No	Handicaps or disabilities	○Yes ○No	Learning disabilities	○Yes ○No
Asthma or lung problems	○Yes ○No	Heart defect (congenital)	○Yes ○No	Rheumatic Fever	○Yes ○No
Blood transfusions	○Yes ○No	Heart murmur	○Yes ○No	Trauma to mouth or face	○Yes ○No
Cancer	○Yes ○No	Hemophilia or abnormal bleeding	○Yes ○No	Tuberculosis (TB)	○Yes ○No
Convulsions or epilepsy	○Yes ○No	Hepatitis	○Yes ○No	Cerebral Palsy	○Yes ○No
Developmental delay	○Yes ○No	High fevers	○Yes ○No	Attention Deficit Disorder	○Yes ○No
Diabetes	○Yes ○No	HIV+ /AIDS	○Yes ○No		

Other medical problems: _____
Please discuss problems further, if necessary:

_____

Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics? ○Yes ○No
Is your child currently taking any medications? ○Yes ○No What kind? _____
Is your child taking any supplemental fluoride? ○Yes ○No If yes, how? ☐Tablets ☐Drops ☐Water ☐Vitamins
Does your child have any breathing problems? ○Yes ○No Breathes primarily through ○Nose ○Mouth
Does your child snore? ○Yes ○No

HABITS

Does your child have any of the following habits?

Thumb or finger sucking ○Yes ○No Pacifier use ○Yes ○No Nail biting ○Yes ○No
Lip sucking or biting ○Yes ○No Biting hard objects ○Yes ○No Tooth grinding ○Yes ○No
Did your child use a bottle? ○Yes ○No If yes, when did he/she stop? _____
Does your child currently use a bottle? ○Yes ○No If yes, how often during the day? _____
Is the bottle used at night? ○Yes ○No What do you put in the bottle? _____
Does your child currently nurse? ○Yes ○No

FAMILY DENTAL HISTORY *(Check appropriate parent, if yes)*

Has ☐Mother or ☐ Father had a lot of decay Has ☐Mother or ☐ Father had orthodontic care?
Does ☐Mother or ☐Father have periodontal disease Does ☐Mother or ☐ Father have TMJ problems?

CHILD'S DENTAL HISTORY

Has your child seen a pediatric dentist before? ○Yes ○No
If yes, the approximate month and year of last visit: _____Where? _____
Has your child had any unfavorable experiences in a dental or medical office? ○Yes ○No
Does your child have any dental problems presently? ○Yes ○No
if yes, please explain: _____
How often does your child brush his/her teeth per day? _____ Do you help? ○Yes ○No
How often does your child floss? _____ Do you floss your child's teeth? ○Yes ○No
How do you think your child will act toward the dentist?_____
Purpose of today's dental visit? _____
Guardian's Initials _____ Date _____ Examining Doctor's Initials _____ Date _____