



Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Pediatric Dentistry  
Health Questionnaire**

Name of person completing health questionnaire: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

The University of Iowa College of Dentistry requests this information for the purpose of providing a complete and comprehensive evaluation of your child's dental needs. No persons outside the University will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your child's needs and may result in the College being unable to accept your child as a patient. Thank you.

**Medical History**

Please circle the appropriate answer:

- Yes No** 1. Does your child have any health problems?
- Yes No** 2. Has there been any change in your child's health in the past year?
- Yes No** 3. Is your child now under medical care?  
If yes, for what? \_\_\_\_\_

4. Does your child have (or has he/she ever had) any of the following conditions?

Yes	No	Allergies	Yes	No	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	a. Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	f. Metals
<input type="checkbox"/>	<input type="checkbox"/>	b. Codeine	<input type="checkbox"/>	<input type="checkbox"/>	g. Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	c. Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	h. Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	d. Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	i. Other _____
<input type="checkbox"/>	<input type="checkbox"/>	e. Latex			

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	j. Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	z. Facial Surgery	<input type="checkbox"/>	<input type="checkbox"/>	pp. Neurologic Disorder
<input type="checkbox"/>	<input type="checkbox"/>	k. ADHD/ ADD	<input type="checkbox"/>	<input type="checkbox"/>	aa. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	qq. Obsessive Compulsive Disorder
<input type="checkbox"/>	<input type="checkbox"/>	l. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	bb. Fever Blisters/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	rr. Oppositional Defiance Disorder
<input type="checkbox"/>	<input type="checkbox"/>	m. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	cc. Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	ss. Pervasive Developmental Disorder
<input type="checkbox"/>	<input type="checkbox"/>	n. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	dd. Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	tt. Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/>	o. Autism Spectrum	<input type="checkbox"/>	<input type="checkbox"/>	ee. High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	uu. Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	p. Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	ff. HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	vv. Respiratory Problems
<input type="checkbox"/>	<input type="checkbox"/>	q. Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	gg. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	ww. Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	r. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	hh. Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	xx. Seasonal Allergies
<input type="checkbox"/>	<input type="checkbox"/>	s. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	ii. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	yy. Seizures
<input type="checkbox"/>	<input type="checkbox"/>	t. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	jj. Hepatitis A, B or C	<input type="checkbox"/>	<input type="checkbox"/>	zz. Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	u. Colitis	<input type="checkbox"/>	<input type="checkbox"/>	kk. Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	aaa. Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	v. Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	ll. Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>	bbb. Stroke
<input type="checkbox"/>	<input type="checkbox"/>	w. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	mm. Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	ccc. Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	x. Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	nn. Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	ddd. Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	y. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	oo. Muscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	eee. Visual Disorders

Yes	No	Adolescents (If older than age 12)
<input type="checkbox"/>	<input type="checkbox"/>	fff. Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/>	ggg. Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	hhh. Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	iii. Sexually Transmitted Disease

Yes	No	Adolescent Females
<input type="checkbox"/>	<input type="checkbox"/>	jjj. Are you taking birth control pills?
<input type="checkbox"/>	<input type="checkbox"/>	kkk. Are you pregnant? If yes, # of weeks: _____
<input type="checkbox"/>	<input type="checkbox"/>	lll. Are you nursing?

**Yes No** 5. Has your child ever been hospitalized or had any surgery?  
Describe:

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**Yes No** 6. If your child had surgery, were there any anesthetic or recovery complications?  
Describe:

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**Yes No** 7. Does your child have or ever had any disease, condition, syndrome or problem not listed here?  
Describe:

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**Yes No** 8. Does your child have any undiagnosed symptoms?  
Describe:

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**Physician List** (Please list your child's physicians and any medical specialists they see)

Name	City	Medical Facility	Type of Specialty

**Dental History**

1. What is the reason you are seeking dental treatment for your child?  
\_\_\_\_\_

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**Yes No** 2. Does your child currently have any dental pain or discomfort?

**Yes No** 3. Do you have any concerns in regards to your child's dental treatment or dental materials used to treat your child?  
\_\_\_\_\_

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**Yes No** 4. Has your child had regular dental check-ups?

5. When was his/her last dental exam? \_\_\_\_\_ By Whom: \_\_\_\_\_

**Yes No** 6. Has your child had any trouble associated with their previous dental treatment?

If yes, please explain: \_\_\_\_\_

**Yes No** 7. Has your child ever had any injuries to their face, jaws, or teeth?

**Yes No** 8. Are you or your child unhappy with the appearance of their teeth?

**Yes No** 9. Has fear or behavior ever prevented your child from receiving dental treatment?

10. Circle the types of dental treatment your child has experienced:

- |                          |                         |                          |
|--------------------------|-------------------------|--------------------------|
| a. Cleanings             | d. Radiographs (x-rays) | g. Fluoride Treatments   |
| b. Fillings              | e. Crowns               | h. Root Canal treatments |
| c. Orthodontics (braces) | f. Oral Surgery         | i. Bleaching             |



