BALSTER PEDIATRIC DENTISTRY

4150 Edgewood Rd NE Ste 2
Cedar Rapids, Iowa 52402

Patient Name _____

Male Female Other

Today's Date_____

Date of Birth _____

Email Address: _____

How did you hear about or office? _____

1. Is your child in good health?.....YES NO
2. Has there been any change in your child's health within the past year?.....YES NO
3. Date of last physical exam _____
4. Is your child now under medical care?.....YES NO
   If so, for what? _____
5. Has your child ever had a serious illness or operation?....YES NO
   If so, explain and date_____
6. Does your child have or has he/she ever had any of the following conditions or diseases?
   a. Rheumatic fever or rheumatic heart disease .....YES NO
   b. Congenital heart disease.....YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke).....YES NO
   d. Allergy or hay fever.....YES NO
   e. Asthma.....YES NO
   f. Hives or skin rash .....YES NO
   g. Fainting spells or seizures.....YES NO
   h. Hepatitis, jaundice, or liver disease.....YES NO
   i. Diabetes .....YES NO
   j. Inflammatory rheumatism (painful, swollen joints)…....YES NO
   k. Arthritis.....YES NO
   l. Stomach ulcers or acid reflux.....YES NO
   m. Kidney trouble .....YES NO
   n. Tuberculosis.....YES NO
   o. Persistent cough or cough up blood.....YES NO
   p. ADHD/ADD/ODD .....YES NO
      If so, specify_____
   q. Autism.....YES NO
   r. Epilepsy.....YES NO
   s. Cerebral palsy.....YES NO
   t. Intellectual disability.....YES NO
      If so, specify _____
   u. Hearing disability.....YES NO
   v. Other developmental disability.....YES NO
      If so, explain _____
   w. **Heart murmur**……..YES NO
   x. Cancer.....YES NO
   y. Cleft lip or palate.....YES NO
   z. Other_____
7. Has your child had abnormal bleeding associated with previous surgery, extractions, or accidents?.....YES NO
8. Does he/she bruise easily?.....YES NO
9. Has he/she ever required a blood transfusion?.....YES NO
10. Does he/she have any blood disorders such as anemia?.YES NO
11. Has he/she ever had surgery or X-ray treatment for a tumor, growth, or other condition? .....YES NO
12. Does your child have a disability that prevents treatment in a dental office?.....YES NO
13. Is he/she taking any of the following?
    a. Antibiotics or sulfa drugs .....YES NO
    b. Anticoagulants (blood thinners) .....YES NO
    c. Medicine for high blood pressure.....YES NO
    d. Cortisone or steroids .....YES NO
    e. Tranquilizers.....YES NO
    f. Aspirin.....YES NO
    g. Dilantin or other anticonvulsant .....YES NO
    h. Insulin, tolbutamide, Orinase, or similar drug .....YES NO
    i. Medicine for ADHD.....YES NO
    j. Any other current medication?
    _____
14. Is he/she allergic to or has he/she ever reacted adversely to any of the following?
    a. Local anesthetics.....YES NO
    b. Penicillin or other antibiotics .....YES NO
    c. Sulfa drugs.....YES NO
    d. Barbiturates, sedatives, or sleeping pills .....YES NO
    e. Aspirin .....YES NO
    f. **Latex**.....YES NO
    g. Do you carry an Epi Pen?.....YES NO

    Any other? _____
15. Has he/she had any serious trouble associated with any previous dental treatment? .....YES NO
    If so, please explain_____
16. Has he/she had any disease, condition, or problem not listed above? .....YES NO
    If so, please explain_____
17. Has your child been in any situation which could expose him/her to X-rays or other ionizing radiations?.....YES NO
18. Has he/she ever had orthodontic treatment (worn braces)? .....YES NO
19. Does your family have a history of congenitally missing or supernumerary teeth?.....YES NO
    If so, please explain_____
20. Has he/she ever been treated for any gum diseases (gingivitis, periodontitis, trench mouth, pyorrhea).....YES NO
21. Do his/her gums bleed when brushing teeth?.....YES NO
22. Does he/she grind or clench teeth? .....YES NO
23. Has he/she often had toothaches? .....YES NO
24. Has he/she had frequent sores in his/her mouth? .....YES NO
25. Has he/she had any injuries to his/her mouth or jaws?.....YES NO
    If so, explain _____
26. Does he/she have any sores or swelling of his/her mouth or jaws? .....YES NO
27. Does your child have a nutritional deficiency or special diet? .....YES NO
28. Does your child have a history of thumb sucking or pacifier habit? ……YES NO
29. Does your child brush twice a day?.....YES NO
30. Does he/she use floss?.....YES NO
31. Do you supervise your child's brushing/flossing?.....YES NO
32. Have you been satisfied with your child's previous dental care? .....YES NO

ADOLESCENTS

33. Are you pregnant? ……YES NO
34. Do you have any problems associated with your menstrual period? .....…YES NO
35. Are you taking the pill? .....YES NO
36. Any history of using cigarettes, e-cigarettes, or vaping? ....YES NO

The undersigned agrees that the information above is accurate.

_____

Guardian's Signature Date

Relationship to child: _____

Balster Pediatric Dentistry requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside of this office 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 needs and may result in Balster Pediatric Dentistry being unable to accept you as a patient.