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Midlothian, VA 23112
804.739.0963

Pediatric Dentistry and
Orthodontics of Virginia
www.pdova.com

651 Southpark Boulevard
Colonial Heights, VA 23834
804.526.9815

Patient/Parent: _____ **DOB:** _____

Parent's Name: _____

**The answers are for office records only and will be considered confidential.
A thorough and complete history is vital to a proper dental evaluation.
For the following questions mark, yes (Y), no (N), or don't know/understand (?).**

Medical History

Now or in the past, has the patient had:

❑Y ❑N ❑? Birth defects or hereditary problems?
❑Y ❑N ❑? Bone fractures, any major accidents?
❑Y ❑N ❑? Endocrine or thyroid problems?
❑Y ❑N ❑? Kidney problems?
❑Y ❑N ❑? Diabetes?
❑Y ❑N ❑? Cancer, tumor, radiation treatment or chemotherapy?
❑Y ❑N ❑? Stomach ulcer or hyperacidity?
❑Y ❑N ❑? Polio, mononucleosis, tuberculosis or pneumonia?
❑Y ❑N ❑? Problems of the immune system?
❑Y ❑N ❑? AIDS or HIV positive?
❑Y ❑N ❑? Hepatitis, jaundice or liver problems?
❑Y ❑N ❑? Fainting spells, seizures, epilepsy or neurological problems?
❑Y ❑N ❑? Mental health illness or behavioral problems?
❑Y ❑N ❑? Vision hearing, tasting or speech difficulties?
❑Y ❑N ❑? History of eating disorder (anorexia, bulimia)?
❑Y ❑N ❑? Excessive bleeding or bruising tendency, anemia or bleeding disorder?
❑Y ❑N ❑? High or low blood pressure?
❑Y ❑N ❑? Cardiovascular problem, inborn heart, defects, heart murmur or rheumatic heart disease)?
❑Y ❑N ❑? Skin disorder?
❑Y ❑N ❑? Does the patient eat a well-balanced diet?
❑Y ❑N ❑? Frequent headaches, colds or sore throat?
❑Y ❑N ❑? Eye, ear, nose or throat condition?
❑Y ❑N ❑? Hayfever, asthma, sinus trouble or hives?
❑Y ❑N ❑? Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

❑Y ❑N ❑? Local anesthetics (Lidocaine)
❑Y ❑N ❑? Ibuprofen (Motrin, Advil)
❑Y ❑N ❑? Penicillin or other antibiotics
❑Y ❑N ❑? Sulfa drugs
❑Y ❑N ❑? Codeine or other narcotics
❑Y ❑N ❑? Metals (jewelry. clothing, snaps)
❑Y ❑N ❑? Latex (gloves, balloons)
❑Y ❑N ❑? Vinyl
❑Y ❑N ❑? Acrylic
❑Y ❑N ❑? Animals
❑Y ❑N ❑? Foods (specify)_____
❑Y ❑N ❑? Other substances, (specify)_____
❑Y ❑N ❑? Is the patient taking medications, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Supplements_____
_____
Medication_____ Taken for:_____
Medication_____ Taken for:_____
Medication_____ Taken for:_____

❑Y ❑N ❑? Does the patient chew or smoke tobacco
❑Y ❑N ❑? Operations?
Describe:_____
❑Y ❑N ❑? Hospitalized?
Describe:_____
❑Y ❑N ❑? Other physical problems/symptoms?
Describe:_____
❑Y ❑N ❑? Being treated by another health care professional?
Describe:_____
For:_____
Date of most recent physical exam?_____
Are there any other medical conditions that we should be aware of?
_____
_____
_____

Meera Gokli, DDS
Pediatric Dentist
Diplomate American
Academy of Pediatric Dentistry

Steven Lubbe, DMD
Pediatric Dentist

April Bridges-Poquis, DDS
Orthodontist

Patient's Name: _____ DOB: _____

Dental History

Now or in the past, has the patient had:

❑Y ❑N ❑? Started teething very early or late?
❑Y ❑N ❑? Primary (baby) teeth removed that weren't loose?
❑Y ❑N ❑? Permanent teeth removed?
❑Y ❑N ❑? Chipped or injured primary or permanent teeth?
❑Y ❑N ❑? Teeth sensitive to hot or cold; throb or ache?
❑Y ❑N ❑? Jaw fractures, cysts or mouth infections?
❑Y ❑N ❑? "Dead teeth" or root canals treated?
❑Y ❑N ❑? Bleeding gums, bad taste or mouth odor?
❑Y ❑N ❑? Periodontal "gum problems"?
❑Y ❑N ❑? Thumb, finger, or sucking habit?
Until what age?_____
❑Y ❑N ❑? History of speech problems?
❑Y ❑N ❑? Mouth breathing habit, snoring, or difficulty breathing?
❑Y ❑N ❑? Tooth grinding, jaw clenching, clicking or locking?
❑Y ❑N ❑? Any pain in jaw or ringing in the ears
❑Y ❑N ❑? Pain or soreness in the face or around the ears?
❑Y ❑N ❑? Difficulty in chewing or jaw opening?
❑Y ❑N ❑? Aware or concerned about under or over developed jaw?
❑Y ❑N ❑? "Gum Boils," frequent canker or cold sores?
❑Y ❑N ❑? Taking any forms of fluoride?
❑Y ❑N ❑? Serious trouble associated with any previous dental treatment?
❑Y ❑N ❑? Prior orthodontic examination or treatment?
❑Y ❑N ❑? Been under another dentist's care?
Specialist: _____
Other:_____

Family Medical History

Do the patient's parents or siblings have any of the following healthy problems? If so, please explain.

Bleeding disorders: _____ Severe allergies::_____

Unusual dental problems::_____ Jaw size imbalance:_____

Metabolic disturbances:_____

Any other family medical conditions that we should know about?_____

How often does your child brush teeth? _____ Floss?_____

What is your primary concern?_____

The undersigned has read and understands the above questions. The undersigned will not hold the orthodontist or any member of his/her staff responsible for any errors or omissions that the undersigned has made in the completion of this form, If there are any changes later to this history record or medical/dental status, the undersigned will so inform this practice.

Signed (Parent or Guardian):_____Print_____

Date Signed::_____