Childs' Name: _____ Date of Birth _____

e-mail: _____ axiUm Chart: _____

GENERAL MEDICAL INFORMATION - PATIENT EVALUATION

Does the child have any of the following diseases or problems? [1.3]

- ☐ Active Tuberculosis
- ☐ Persistent cough greater than 3 weeks in duration
- ☐ Cough that produces blood
- ☐ Been exposed to anyone with Tuberculosis
- ☐ No

Is the child now, or has the child been in the past year, under the care of a physician? [1.5]

- ☐ Yes
- ☐ No

Are there any conditions that necessitate the child taking medication prior to dental treatment? [1.4]

- ☐ Yes
- ☐ No

Has there been any change in the child's general health within the past year? [1.6]

- ☐ Yes
- ☐ No

Has the child had any serious illness, operation, or been hospitalized in the past 5 years? [1.7]

- ☐ 0-6 MONTHS
- ☐ 6-12 MONTHS
- ☐ 1-2 YEARS
- ☐ 2-5 YEARS
- ☐ No

Are the child's immunizations up to date? [1.8]

- ☐ Yes
- ☐ No

Does the child use or has the child used tobacco (smoking, snuff, chew, bidis)? [1.9]

- ☐ Currently
- ☐ Past
- ☐ Never

Does the child use or has the child used prescription or street drugs or other substances for recreational purposes? (Cocaine, Ecstasy, Heroin, Marijuana, Methamphetamine, Oxycontin, Other) [1.10]

- ☐ Past
- ☐ Currently
- ☐ Never

Medications:

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)? [1.1]

Medication	Dosage	Frequency

ALLERGIES

Is the child allergic to, or has the child had a reaction to any of the following? [1.2]

- ☐ Local anesthetics (Novocaine/Epinephrine) Reaction _____
- ☐ Penicillin Reaction _____
- ☐ Hay fever/seasonal (allergic rhinitis) Reaction _____
- ☐ Food Specify _____ Reaction _____
- ☐ Latex (rubber) Reaction _____
- ☐ Other/Other medications Reaction _____
- ☐ None

MEDICAL CONDITIONS: Do you have or have you had any of the following diseases, problems, or symptoms?

Heart/Blood Pressure problem? [1.18]
- ☐ Congenital heart defect
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Rheumatic fever/Rheumatic heart disease
- ☐ Other
- ☐ None

Respiratory/Lung problem? [1.23]
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Snoring
- ☐ Tuberculosis
- ☐ Other
- ☐ None

Diabetes/Endocrine disorder? [1.14]
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ Other
- ☐ None

Growth/Development Problem? [1.16]
- ☐ Behavioral problem
- ☐ Developmental delay
- ☐ Excessive nervousness
- ☐ Genetic disorder
- ☐ Intellectual/Learning disability
- ☐ Physical growth problem
- ☐ Premature birth/Pregnancy complications
- ☐ Other
- ☐ None

Kidney/Urinary disorder? [1.20]
- ☐ Yes
- ☐ No

Neurologic/Nerve problem? [1.22]
- ☐ ADD/ADHD (attention deficit disorder)
- ☐ Cerebral palsy
- ☐ Convulsions
- ☐ Fainting or dizzy spells
- ☐ Loss of consciousness
- ☐ Psychiatric disease/Mental health disorder
- ☐ Seizures/Epilepsy
- ☐ Other
- ☐ None

Illnesses/Infectious disease? [1.19]
- ☐ AIDS
- ☐ Chicken Pox
- ☐ HIV
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Scarlet fever
- ☐ STD (sexually transmitted disease)
- ☐ Other
- ☐ None

Muscle/Bone/Connective Tissue disorder? [1.21]
- ☐ Arthritis
- ☐ Other
- ☐ None

Stomach/Intestine/Liver disorder? [1.24]
- ☐ Hepatitis
- ☐ Jaundice (skin/eyes turn yellow)
- ☐ Other
- ☐ None

Blood/Hematologic disorder? [1.11]
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Bruise easily
- ☐ Sickle cell disease
- ☐ Other
- ☐ None

Head/Eye/Ear/Nose/Throat problem? [1.17]
- ☐ Chronic adenoid/tonsil infections
- ☐ Cleft lip/Cleft palate
- ☐ Hearing impairment
- ☐ Speech impairment
- ☐ Vision problem
- ☐ Other
- ☐ None

Cancer or Tumors? [1.12]
- ☐ Yes
- ☐ No

Dermatologic/Skin problem? [1.13]
- ☐ Yes
- ☐ No

Eating disorder? [1.15]
- ☐ Yes
- ☐ No

Please add comments or notes here for medical information not addressed by the above questions. [1.25]

For Marquette University Dental School Staff

Process date _____ Process 1 _____ Process 2 _____ Process 3 _____

Dental History

PAST DENTAL TREATMENT

Has the child been to the dentist before? [2.1] ☐ Yes ☐ No

If yes:	0-6 MONTHS	6-12 MONTHS	1-2 YEARS	More than 2 YEARS
How long ago was your last dental visit?	☐	☐	☐	☐
How long ago was your last dental exam?	☐	☐	☐	☐
How long ago was your last dental x-ray	☐	☐	☐	☐
How long ago was your last dental cleaning?	☐	☐	☐	☐

Has the child ever had orthodontic (braces) treatment? [2.2] ☐ Yes ☐ No

DENTAL PROBLEMS (SIGNS/SYMPTOMS)

Is the child currently experiencing dental pain or discomfort? [2.3] ☐ Yes ☐ No

Has the child ever had an injury to their head or mouth? [2.4] ☐ Yes ☐ No

DENTAL DISEASE PREVENTION (ORAL HYGIENE/DIET)

How often does the child brush their teeth? [2.6]

- ☐ SOMETIMES
- ☐ ONCE A DAY
- ☐ TWICE A DAY
- ☐ MORE THAN TWICE A DAY
- ☐ Never

How often does the child floss their teeth? [2.7]

- ☐ SOMETIMES
- ☐ ONCE A WEEK
- ☐ ONCE A DAY
- ☐ MORE THAN ONCE A DAY
- ☐ Never

How do you expect your child to react in the dental chair? [2.13]

- ☐ Very good
- ☐ Good
- ☐ Poor
- ☐ Very Poor

Does the child have adequate fluoride exposure [2.9]?

- ☐ Lives or goes to school in a fluoridated community
- ☐ Fluoride toothpaste used at least once per day
- ☐ Fluoride mouth rinse used daily
- ☐ Topical fluoride treatment within the last 6 months
- ☐ Fluoride varnish treatment within the last 6 months
- ☐ No

Does the child snack between meals more than 3 times daily and/or have a diet high in carbohydrates (sugar, starch)? [2.10]

- ☐ Frequent Snacking
- ☐ Diet high in carbohydrates
- ☐ No

Does the child clench, and/or brux(grind) their teeth? [2.11]

- ☐ CLENCH
- ☐ BRUX/GRIND
- ☐ BOTH
- ☐ None

Does the child clench, suck their thumb, finger and/or pacifier? [2.12]

- ☐ Thumb
- ☐ Finger
- ☐ Pacifier
- ☐ None

To the best of my knowledge, I have answered every question completely and accurately.

Parent/Legal Guardian Signature: _____ Date: _____

For Marquette University Dental School Clinic Use Only

Use this section to record student and faculty signatures designating review and approval of the patient health history for existing patients until the health history is fully incorporated into the electronic health record.

Student signature/ID#: _____ Date: _____

Faculty signature/ID #: _____ Date: _____