Akoya Pediatric Dentistry
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(954) 799-6212

Medical History Form

PATIENT FIRST NAME

DATE OF BIRTH (MM/DD/YYYY) *

MM/DD/YYYY

PATIENT LAST NAME

GENDER

Medical HIstory

IS YOUR CHILD IN GOOD HEALTH? *
- Yes
- No

NAME OF PEDIATRICIAN:

OFFICE PHONE NUMBER:

(___) ___-____

PEDIATRICIAN ADDRESS:

DATE OF LAST VISIT:

REASON FOR LAST VISIT:

DOES YOUR CHILD SEE ANY OTHER PHYSICIANS OR SPECIALISTS? *
- Yes
- No

HAS YOUR CHILD HAD ANY SERIOUS ILLNESS OR INJURY? *
- Yes
- No

WAS YOUR CHILD BORN PREMATURE? *
- Yes
- No

WAS YOUR CHILD DELIVERED BY CESAREAN SECTION? *
- Yes
- No

HAS YOUR CHILD BEEN HOSPITALIZED OR HAD SURGERY? *
- Yes
- No

HAS YOUR CHILD'S TONSILS OR ADENOIDS BEEN REMOVED? *
- Yes
- No

ANY COMPLICATIONS WITH GENERAL ANESTHESIA OR ANY TYPE OF SEDATION? *
- ◯ Yes
- ◯ No

DOES YOUR CHILD'S SIBLINGS HAVE CAVITIES?
- ◯ Yes
- ◯ No
- ◯ Unsure

Does your child have or has your child had any of the following?

None

View list

Does your child have or has your child had any of the following?

HEART MURMUR: *
- ◯ Yes
- ◯ No

BLEEDING DISORDERS: *
- ◯ Yes
- ◯ No

ARTIFICIAL JOINTS OR VALVES: *
- ◯ Yes
- ◯ No

SPECIAL NEEDS: *
- ◯ Yes
- ◯ No

CURRENT OR HISTORY OF CANCER: *
- ◯ Yes
- ◯ No

ASTHMA OR BREATHING PROBLEMS: *
- ◯ Yes
- ◯ No

SEIZURES: *
- ◯ Yes
- ◯ No

DIABETES: *
- ◯ Yes
- ◯ No

DOES YOUR CHILD HAVE OTHER MEDICAL CONDITIONS NOT LISTED ABOVE? *
- ◯ Yes
- ◯ No

IS YOUR CHILD IN ANY TYPE OF THERAPY? *
- ◯ Yes
- ◯ No

HAS YOUR CHILD HAD ANY ABNORMAL BLEEDING WITH A PREVIOUS EXTRACTION, SURGERY, OR TRAUMA: *
- ◯ Yes
- ◯ No

DOES YOUR CHILD TAKE ANY MEDICATIONS? *
- ◯ Yes
- ◯ No

DOES YOUR CHILD TAKE ANY VITAMINS, SUPPLEMENTS, OR ALTERNATIVE MEDICINES? *
- ◯ Yes
- ◯ No

DOES YOUR CHILD HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE SHOULD KNOW ABOUT? *
- ◯ Yes
- ◯ No

DOES YOUR CHILD HAVE ANY ALLERGIES? *
- ◯ Yes
- ◯ No

Dental History

HAS YOUR CHILD EVER HAD A DENTAL TRAUMA? *

- ◯ Yes
- ◯ No

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

- ☐ Cavities
- ☐ Bleeding gums
- ☐ History of antibiotics
- ☐ Discoloration
- ☐ Bad breath
- ☐ Dry mouth
- ☐ Orthodontic treatment

Diet & Habits

IS THE CHILD BREASTFEEDING CURRENTLY? *

- ◯ Yes
- ◯ No

BOTTLE FEEDING: *

- ◯ Yes
- ◯ No

USING A SIPPY CUP? *

- ◯ Yes
- ◯ No

DOES THE CHILD USE A PACIFIER: *

- ◯ Yes
- ◯ No

DOES THE CHILD SUCK THEIR THUMB/FINGER? *

- ◯ Yes
- ◯ No

DOES YOUR CHILD DO ANY OF THE FOLLOWING?

- ☐ Have frequent snacks in between meals [more than 2-3]
- ☐ Eat sugary foods and drinks
- ☐ Eat acidic foods and drinks
- ☐ Have a sweet tooth

DOES CHILD PLAY ANY SPORTS? *

- ◯ Yes
- ◯ No

WHAT ARE THE CHILD'S HOBBIES OR INTERESTS?

AS YOUR HEALTHCARE PARTNERS, WE AIM TO OFFER OUTSTANDING PREVENTIVE CARE AND PERSONALIZED ORAL HYGIENE SOLUTIONS. EXPLORE YOUR OPTIONS AND RECEIVE TAILORED RECOMMENDATIONS. WHAT INTERESTS YOU? SELECT ALL THAT APPLY:

- ☐ Tips to foster regular brushing and flossing habits alternatives
- ☐ Strategies to effectively reduce cavity risk
- ☐ Tasty toothpaste flavors
- ☐ Alkaline, non-burning mouthwash options
- ☐ Non-toxic floss infused with toothpaste
- ☐ Healthy non-fluoride oral care
- ☐ Ideal toothbrushes for all ages
- ☐ Customized Comprehensive oral care plans
- ☐ All-natural teeth whitening solutions
- ☐ Our secret arsenal for conquering bad breath

WHAT OTHER AREAS WOULD YOU LIKE HELP WITH?

By signing below, I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

DRAW YOUR SIGNATURE INTO THE BOX BELOW *

Clear

RELATIONSHIP TO THE PATIENT

NAME IF NOT THE PATIENT

DATE

04-29-2025