UNIVERSITY OF MICHIGAN SCHOOL OF DENTISTRY
Pediatric Dentistry Standard Health Questionnaire

PATIENT NAME _____ AGE _____ GENDER _____ BIRTH DATE _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

PHYSICIAN'S NAME _____ CITY _____ PHONE _____

1	Is the patient experiencing pain/discomfort/swelling or toothaches? (circle one)	Y	N
2	Is this the first dental visit ***ever*** for this patient?	Y	N
3	Is this patient under treatment by a physician for routine or special care? *If YES, describe* _____	Y	N
4	Is this patient taking any medications? *Please list* _____	Y	N
5	Has this patient ever been seriously sick, hospitalized or had surgery?	Y	N
6	Has a physician ever told you that this patient has a heart murmur?	Y	N
7	Is this patient physically, mentally or emotionally disabled? *If YES, you must complete the* ***Supplemental Health Form on reverse side***	Y	N
8	Does this patient have a learning disability? _____	Y	N
9	Has this patient ever had any history of the following? *If YES, check the appropriate space below:* _____ Anemia _____ Kidney or Liver Disorders _____ Asthma _____ Childhood Diseases (mumps, measles) _____ Diabetes _____ Seizures/Epilepsy _____ Heart Disorders _____ Tuberculosis _____ Hepatitis _____ Infectious Disease _____ HIV/AIDS _____ *Other* _____	Y	N

Dental Provider Comments _____

10	Is the patient allergic to any medications or products? (such as penicillin, artificial flavors or colors, rubber latex, other)? *Please list* _____	Y	N
11	Has the patient ever had any history of the following oral habits? _____ Pacifier _____ Mouth Breathing _____ Grinds Teeth _____ Thumb/Finger Sucking _____ Nail Biting _____ Tobacco Use _____ Other _____	Y	N
12	Is the patient pregnant? *If YES, when is the approximate due date?* _____	Y	N
13	What is the drinking water source for this patient (check all that apply)? _____ City Water/Name of City _____ Do you use a water filter? _____ _____ Private Well _____ Bottled Water	Y	N
14	Previous significant trauma to face or jaw? *If YES, describe* _____	Y	N
15	Do you anticipate this patient having difficulty accepting dental treatment?	Y	N
16	Are you anxious or fearful for this visit?	Y	N
17	Do you or your child's caretaker have any untreated dental needs?	Y	N

How do you prefer to be contacted regarding *feedback* about your visits to our clinic?
Email _____ Text _____ Contact Info: _____

Parent/Guardian Signature _____ Relationship to Patient _____

Parent/Guardian Printed Name _____ Today's Date _____

Pediatric Dentistry *Supplemental Health Form*

Please Complete ONLY If You Answered "YES" To Question 7 On The Reverse Side

1	What are the physical, intellectual or emotionally disabling conditions for this patient? Specify one or more, if needed _____ _____ _____
2	Can this patient talk and understand at her/his age level? _____Yes _____No If NO, at what level? _____
3	Do we need to give simple commands for safe dental treatment? _____Yes _____No If YES, please explain _____
4	Does the patient have any difficulty or history of any of the following: _____Speech _____Vision _____Hearing _____Swallowing _____Other _____None Please describe _____
5	Can this patient perform toilet activities unaided? _____Yes _____No
6	Does this patient follow verbal directions easily? _____Yes _____No
7	Does this patient attend special classes in school? _____Yes _____No If YES, how many days per week? _____ Goals of class _____
8	Describe this patient's behavior and progress in school. _____ _____
9	Is this patient in residence of a: _____ Group Home _____Care Facility _____ Parents/Guardian _____Other_____
10	Who is the physician that we may contact for additional information about the physical or intellectual disability of this patient? Name _____ Phone_____ Address _____ City _____ When was the patient last seen by this physician? _____ Has the physician prescribed any medication for this patient? _____Yes _____No If YES, what are the medications? _____ _____
11	Is this patient a patient of record at a medical center? _____Yes _____No If YES, what is the name of the medical center and the phone number? _____ _____ Phone_____
12	Is there anything else you feel we should now about this patient? _____Yes _____No If YES, please explain _____ _____ _____ _____