MEDICAL INFORMATION

Mr. No. _____ **Date of Visit _____**

I. General Information

Patient Name: _____ Age: _____ Birth date: __ /___ /___ Gender: __Male __ Female

Name of Parent/Guardian: _____

Phone Number/ Mobile No: _____

1. Describe the nature of your child's condition?_____

2. What was the Dr.'s diagnosis? _____

3. When was he/she diagnosed?

_____

4. Was the diagnosis **__Mild __ Moderate __Severe**

5. What other supportive therapies does your child receive? .**Please lists the/she m all.**

_____

6. Has your child ever had seizure? **__ Yes __ NO**

Type of Seizure: _____

7. Does your child have any allergies? **__Yes __ No** if **yes**, please list: _____

8. Does your child wear a hearing aid? **__ Yes __No** If **yes**, please explain: _____

9. Does your child have any other physical challenges that he/she dental team should be aware of?

_____

II. Oral Care

1. Has your child visited the dentist before? **__ Yes __ No**

If **yes**, please describe: _____

2. Was he/she willing to sit on the chair to follow instructions? **__ Yes __ No**

3. How many meals does your child have during the day? __1 __2 __3 __4 __and more

and how often does your child snack during the day? ? __1 __2 __3 __4 __and more

what does he/she prefer to snack on? _____

4. Does your child allow you to brush? **__ Yes __ No**

How many times per day? __1 __2 __3

5. Does your child like or dislike the/she toothpaste? **__ Yes __ No**

Which toothpaste are you using? _____

III. Communication and Behavior

1, Is your child able to communicate verbally? **__ Yes __ No**

2. Are there preferred words/ phrases that might help dental team? _____

3. Does your child use non-verbal communication? **__ Yes __ No**

III Sensory Issues

1 . Is your child sensitive to bright lights? **__ Yes __ No**

2. Does your child prefer to be quiet? **__ Yes __ No**

3. Is your child sensitive to sounds? **__ Yes __ No**

4. Does your child listen to music? **__ Yes __ No**

5. My child's favorite music is _____

6. My child's favorite cartoon / movie is _____

7. My child's favorite snack is _____

8. Is your child more comfortable in a clutter-free environment? **__ Yes __No**

9. Is your child sensitive to motion and moving ie. the dental chair, moving up and down or to a reclining position. Please explain.

_____

6. Does your child have any specific oral sensitivity? (Gagging, gum sensitivities, etc.) _____

7. Do certain tastes bother your child? **__ Yes __ No**

Please feel free to bring objects that are pleasurable and comforting for your child in the dental clinic

_____

Parent / Guardian's Signature

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