

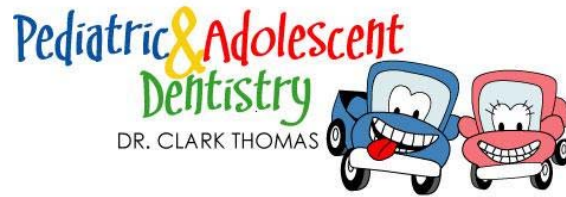
QUESTIONNAIRE FOR PARENTS OF PATIENTS WITH SPECIAL NEEDS

Child's name _____

Date _____

In order for us to better serve your child, we would appreciate your cooperation in completing this questionnaire. There may be some duplicate questions that coincide with our general health history form; if the answer is extensive, please make a note that refers our office to the correct form.

- 1) What is your child's diagnosed medical condition(s)?
- 2) When was this condition first diagnosed/discovered?
- 3) If your child sees a specialist(s) for this condition, please list their names and phone numbers:
Doctor's Name _____
Specialty Field _____ Phone # _____
- 4) Birthday: _____ What is your child's exact age in years and months?
_____ years _____ months
- 5) What is your child's approximate developmental age? _____ years
- 6) At what level does your child communicate verbally?
_____ normally (no delay) _____ mild delay _____ moderate delay _____ does not speak
- 7) Is your child receiving medication for the condition and, if so, which medications is your child currently taking, and the dosage? _____ No medicines _____ Yes (please list info)
- 8) Has your child's physician told you that your child needs to be premedicated (antibiotic coverage)



before dental services can be provided? ____NO ____YES (if "yes", confirm that your child's pediatric cardiologist's name and office number are listed in Question 3)

9) Does your child have any allergies to medicines, blood disorders, or heart problems?

If so, please explain.

10) Is this your child's first visit to a dentist? ____NO ____YES

11) Has your child had any negative dental experiences and, if so, please describe?

____NO ____YES....

12) What does your child like to do? Hobbies, favorite foods, etc.?

13) Anything else you would like us to know?