MEDICAL HISTORY

Patient Name: _____ Date: _____

_____
NAME OF CHILD'S PEDIATRICIAN

_____
ADDRESS PHONE

□ Yes □ No ● Is your child presently under the care of a specialist for any medical reason? If yes, what?

_____
_____
SPECIALIST NAME PHONE

□ Yes □ No ●Does your child have a history of health problems?
If yes, explain: _____

□ Yes □ No ● Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt or other medical reason?

□ Yes □ No ● Is your child presently taking any medications?
Type and Dose: _____

□ Yes □ No ● Has your child had a history of taking medications frequently?

□ Yes □ No ● Has your child ever been hospitalized or had surgery?
For What? _____

□ Yes □ No ● Is your child allergic to any latex, metals, or acrylics?
If yes, what? _____

□ Yes □ No ● Does your child have any other allergies? If yes, what? _____

□ Yes □ No ●Is this your child's first dental visit?

_____
If no, previous dentist? When?

□ Yes □ No ●Any injuries to your child's teeth or jaws?
When? _____

□ Yes □ No ●Has your child had recent dental pain?

□ Yes □ No ●Has your child experienced any unfavorable reaction from previous medical or dental care?
If yes, please explain: _____
_____

History of:	**When?**
●Nursing bottle habits	_____
●Thumb/finger sucking	_____
●Pacifier	_____
●Teeth grinding or clenching	_____

_____
Parent Signature Date

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

□ Yes □ No AIDS-HIV-STD'S
□ Yes □ No Anemia, Hemophelia, Bleeding disorders
□ Yes □ No Asthma, Cystic Fibrosis, Resp diseases
□ Yes □ No Autism
□ Yes □ No Blood Disease
□ Yes □ No Blood Transfusions
□ Yes □ No Birth Defects
□ Yes □ No Bone or Joint problems, Arthritis
□ Yes □ No Brain Injury
□ Yes □ No Bruising Easily
□ Yes □ No Cancer or Malignancies
□ Yes □ No Chemotherapy, Radiation
□ Yes □ No Child Abuse
□ Yes □ No Chronic Adenoid/Tonsil Infection
□ Yes □ No Cleft Lip/Palate
□ Yes □ No Congenital Heart Lesion
□ Yes □ No Diabetes, Thyroid, or Endocrine Disease
□ Yes □ No Emotional Disturbance
□ Yes □ No Neurological Disease
□ Yes □ No Eye Problems
□ Yes □ No Excessive Gagging
□ Yes □ No Fainting or Dizziness
□ Yes □ No Growth and Development Problems
□ Yes □ No Heart Surgery
□ Yes □ No Headaches
□ Yes □ No Hearing/Speech Impairments
□ Yes □ No Heart Murmur, Defect, Congenital Heart Disease
□ Yes □ No Hepatitis or Liver Disease
□ Yes □ No Hyperactivity/ADD
□ Yes □ No Kidney Disease/Bladder Problems
□ Yes □ No Mental or Developmental Delay
□ Yes □ No Mouth Sores
□ Yes □ No Pain in Jaw Joints
□ Yes □ No Psychiatric Care
□ Yes □ No Rheumatic Fever
□ Yes □ No Sickle Cell Anemia or Trait
□ Yes □ No Syndrome _____
□ Yes □ No Other _____
□ Yes □ No Do you wish to talk to the doctor privately about a special concern?

How do you think your child will act toward the dentist? _____
_____