

MEDICAL HISTORY

Child's Name: _____ Age _____ Date of Birth _____ Male Female

Parent/Legal Guardian's Name: _____

Address: _____

Cell Phone _____ Home Phone _____ Work Phone _____

How did you hear about our office? _____

What is the reason for your visit today? _____

Has your child ever had the following: **(CIRCLE YES OR NO)**

YES NO ADD/ ADHD	YES NO Hemophilia	YES NO Prolonged/ Abnormal bleeding
YES NO Autism	YES NO Hepatitis A, B, C	YES NO Psychiatric Care
YES NO Birth Defects	YES NO HIV positive/ AIDS	YES NO Seizure Disorder/Epilepsy
YES NO Blood Transfusion	YES NO Hypoglycemia	YES NO Shunt
YES NO Bruise Easily	YES NO Jaw difficulty: TMJ	YES NO Sickle Cell Anemia/Trait
YES NO Cerebral Palsy	YES NO Juvenile Rheumatoid Arthritis	YES NO Sleep Apnea
YES NO Cleft Lip or Palate	YES NO Kidney Problems	YES NO Speech or hearing problems
YES NO Diabetes	YES NO Mental Retardation	YES NO Spina Bifida
YES NO Downs Syndrome	YES NO Organ Transplant	YES NO Stomach/Liver/Kidney Problems
YES NO Handicaps/Disabilities		YES NO Tuberculosis (TB)

LUNGS

YES NO Asthma
 If YES for Asthma what triggers an attack? **(circle one)**
 Allergies Exercise / Exertion Stress
 YES NO Medications used to treat **(circle one)**
 Albuterol Nebulizer Steroids No Medications
 Other medication (list here) _____
 YES NO Ever been to the Emergency Room for an attack?
 If YES how many times in the past 3 years? _____

CANCER

YES NO Cancer
 YES NO Chemotherapy
 YES NO Leukemia
 YES NO Radiation Treatment
 If YES which type of cancer?

ALLERGIES

YES NO Amoxicillin / Penicillin	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES NO Cephalosporin / Keflex	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES NO Codeine	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES NO Erythromycin	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES NO Latex	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES NO Tetracycline	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES NO Sulfa	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic

HEART

If YES who is cardiologist?
 YES NO Congenital Heart Defect Name _____
 YES NO Heart Murmur Phone _____
 YES NO Irregular Heart Beat
 YES NO Mitral Valve Prolapse
 YES NO Open Heart Surgery
 YES NO Patent Ductus Arteriosus (PDA) Who is your Pediatrician
 YES NO Prolonged Q-T Interval Name _____
 YES NO Rheumatic Fever
 YES NO Scarlet Fever
 YES NO Ventricular Septal Defect (VSD) Phone _____
 YES NO Has your child ever been told to take antibiotics before dental treatment?

ADOLESCENT FEMALE PATIENTS

YES NO Is the patient PREGNANT ?
 YES NO Is the patient taking BIRTH CONTROL PILLS?

List any other problems / hospitalizations your child has had:

List any other medications being taken: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of parent or Guardian _____ Date _____