MEDICAL HISTORY

Although dental personnel primarily treat the area in and around the mouth, the mouth is a part of your entire body. Health problems or medications could have an important interrelationship with the dentistry you will receive.

Patient Name ____ **Birth Date**__________________________

Name of child's physician____ Date of last physical exam? _____________________

Has your child ever been hospitalized or had an operation/surgery? □Yes □No If Yes:__________________________

Has your child ever had a serious head or neck injury? □Yes □No If Yes:__________________________

Is your child taking any medications, pills, or drugs? □Yes □No If Yes:__________________________

Is your child on a special diet? □Yes □No If Yes:__________________________

Is your child allergic to any of the following? □Yes □No

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Other

If Yes, please explain:____

Does your child have, or has he/she had, any of the following? * (**you must mark Yes or No for each question**)

Asthma	□Yes	□No	Cortisone Medicine	□Yes	□No	Hemophilia	□Yes	□No	Diabetes	□Yes	□No
Other Breathing Problems	□Yes	□No	Lung Disease	□Yes	□No	Anaphylaxis	□Yes	□No	Hypoglycemia	□Yes	□No
Seasonal Allergies	□Yes	□No	Blood Disorder	□Yes	□No	Rheumatic Fever	□Yes	□No	High Blood Pressure	□Yes	□No
Epilepsy or Seizures	□Yes	□No	Anemia	□Yes	□No	Scarlet Fever	□Yes	□No	Low Blood Pressure	□Yes	□No
Tonsillitis	□Yes	□No	Leukemia	□Yes	□No	Artificial Joint	□Yes	□No	Down Syndrome	□Yes	□No
Otitis Media (Ear Infection)	□Yes	□No	Sickle Cell Disease	□Yes	□No	Cerebral Palsy	□Yes	□No	Sensory Issues	□Yes	□No
Sinus Trouble	□Yes	□No	Liver Disease	□Yes	□No	Kidney Problems	□Yes	□No	Autism	□Yes	□No
AIDS/HIV Positive	□Yes	□No	Hepatitis	□Yes	□No	Stomach/Intestinal Disease	□Yes	□No	ADD/ADHD	□Yes	□No
Frequent Headaches	□Yes	□No	Congenital Heart Disorder	□Yes	□No	Bruise Easily	□Yes	□No	Developmental Delay	□Yes	□No
Cancer	□Yes	□No	Artificial Heart Valve	□Yes	□No	Thyroid Disease	□Yes	□No	Psychiatric Care	□Yes	□No
Cold Sores/Fever Blisters	□Yes	□No	Mitral Valve Prolapse	□Yes	□No	Parathyroid Disease	□Yes	□No	Tuberculosis	□Yes	□No
Tumors or Growths	□Yes	□No	Heart Murmur	□Yes	□No	Jaundice	□Yes	□No			

*__Please explain any "Yes" answers above__:

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Has your child ever had any serious illness not listed above? □Yes □No If Yes, please explain:

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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 _______________

Signature of Doctor____ Date_______________