CHILD'S MEDICAL HISTORY

These questions are to help the doctors understand your child better and allow the best treatment for your child. Thank you.

Name____________________ **M ❑ F ❑ Date of Birth** ____/____/____ **Acct. #**________

1. Who is your child's physician? ____________________. Phone # ____________
2. Has your child ever been hospitalized? Yes ❑ No ❑ if so, when and why? ____________________
3. Is your child allergic to any of the following drugs?

Penicillin/Amoxicillin	Yes ❑	No ❑	Sulfa	Yes ❑	No ❑	Augmentin	Yes ❑	No ❑
Erythromycin	Yes ❑	No ❑	Tetracycline	Yes ❑	No ❑	Ceclor	Yes ❑	No ❑
Dental Anesthetic	Yes ❑	No ❑	Aspirin	Yes ❑	No ❑	Latex	Yes ❑	No ❑

List any drug or food allergies ____________________

Is your child taking medications presently? Please list ____________________

4. Has your child ever had any of the following medical problems?

Asthma	Yes ❑	No ❑	Epilepsy/Convulsions	Yes ❑	No ❑	Liver disease	Yes ❑	No ❑
Birth defects	Yes ❑	No ❑	Fainting spells	Yes ❑	No ❑	Mental retardation	Yes ❑	No ❑
Bleeding/Blood Problems	Yes ❑	No ❑	Hearing loss/impairment	Yes ❑	No ❑	Psychiatric problems	Yes ❑	No ❑
Cancer	Yes ❑	No ❑	Heart condition/murmur	Yes ❑	No ❑	Radiation Therapy	Yes ❑	No ❑
Cerebral Palsy	Yes ❑	No ❑	Hepatitis	Yes ❑	No ❑	Sickle cell anemia	Yes ❑	No ❑
Chronic ear infections	Yes ❑	No ❑	HIV/AIDS	Yes ❑	No ❑	Skin disorders	Yes ❑	No ❑
Delayed speech development	Yes ❑	No ❑	Hyperactivity/ADHD	Yes ❑	No ❑	Snoring	Yes ❑	No ❑
Developmental delay	Yes ❑	No ❑	Joint diseases	Yes ❑	No ❑	Smoking	Yes ❑	No ❑
Diabetes	Yes ❑	No ❑	Kidney disease	Yes ❑	No ❑	Tuberculosis	Yes ❑	No ❑
Down's syndrome	Yes ❑	No ❑	Learning disabilities	Yes ❑	No ❑	Tumors	Yes ❑	No ❑

Please explain all yes answers and/or other medical problems not listed ____________________

5. Is this your child's first dental visit? Yes ❑ No ❑ If no, date of last exam ____/____/____.
6. Is this an emergency visit Yes ❑ No ❑ please specify any dental problems. ____________________
7. Has your child ever had difficult problems associated with previous dental work? Yes ❑ No ❑ please explain. ____________________
8. Do you have well water? Yes ❑ No ❑
9. Is your child taking fluoride supplements? Yes ❑ No ❑
10. Any family history of braces? Yes ❑ No ❑
11. Family history of missing teeth? Yes ❑ No ❑
12. Do parents help brush/floss? Yes ❑ No ❑
13. Does the child brush/floss daily? Yes ❑ No ❑
14. Does your child have any of the following habits?
    - Pacifier habit past 1 Yr. Old Yes ❑ No ❑
    - Thumb/Finger Sucking Yes ❑ No ❑
    - Lip Sucking Biting Yes ❑ No ❑
    - Nail Biting Yes ❑ No ❑
    - Nursing Bottle habits past 1 Yr. Old Yes ❑ No ❑
15. Diet/snack habits/concerns ____________________

Names and Ages of Siblings ____________________

MEDICAL ALERT

Because your child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any/or all necessary dental treatment be performed by our pediatric dentists.

The signature of the parent or guardian below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, I will be responsible for any bill on this child for dental treatment.

Signed ____________________ Date__________.

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Signed ____________________ Date__________.
Doctor/Hygienist

Updated ____________
Sig (Parent) ____________
Sig (Dr./Hyg.) ____________

Updated ____________
Sig (Parent) ____________
Sig (Dr./Hyg.) ____________

Updated ____________
Sig (Parent) ____________
Sig (Dr./Hyg.) ____________

Updated ____________
Sig (Parent) ____________
Sig (Dr./Hyg.) ____________