Medical History

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

Parent or Legal Guardian Name: _____

Address: _____ Cell Phone: (_____) _____

City: _____ State: _____ Zip: _____ Home Phone: (_____) _____

County: _____ _____ E-mail: _____

Name of other children: _____

Mother's Occupation: _____ Mother's Work Phone: (_____) _____

Father's Occupation: _____ Father's Work Phone: (_____) _____

How did you hear about or office? _____

What is the reason for your visit today? _____

Has your Child ever had the following? (Circle YES or NO for each)

YES / NO **Birth Defects**
YES / NO **Down's Syndrome**
YES / NO **Mental Retardation**
YES / NO **Cerebral Palsy**
YES / NO **Spina Bifida**
YES / NO **Cleft Lip or Palate**
YES / NO **Handicaps/Disabilities**
YES / NO **Speech or Hearing problems**
YES / NO **Psychiatric Care**
YES / NO **Autism**
YES / NO **ADD/ADHD**
YES / NO **Asthma**
YES / NO **HIV Positive/ AIDS**

YES / NO **Jaw Difficulty: TMJ**
YES / NO **Stomach/Liver/Kidney Problem**
YES / NO **Sleep Apnea**
YES / NO **Seizure Disorder/Epilepsy**
YES / NO **Sickle Cell Anemia/Trait**
YES / NO **Hepatitis A, B, or C**
YES / NO **Juv. Rheumatoid Arthritis**
YES / NO **Organ Transplant**
YES / NO **Blood Transfusions**
YES / NO **Diabetes**
YES / NO **Hemophilia**
YES / NO **Tuberculosis**

YES / NO **LATEX ALLERGY**
YES / NO **Congenital Heart Defect**
If so what type?_____
YES / NO **Prolonged QT Interval**
YES / NO **Irregular Heart Beat/Arrhythmia**
YES / NO **Heart Murmur**
YES / NO **Rheumatic Fever**
YES / NO **Shunt**
YES / NO **Kawasaki's Disease**
YES / NO **Prolonged/Abnormal Bleeding**
YES / NO **Cancer**
If so, type/treatment_____
_____

Other medical conditions not listed above: _____

List Hospitalizations/Surgeries _____

If your child has a history of **ASTHMA** What triggers an attack? Unknown Exercise Allergies Stress
How many times has he/she been to an ER for an attack in the last 3 years?

YES / NO Are there any **ALLERGIES** or adverse drug reactions to any foods/medications (**Penicillin, Codeine, Red Dye, Strawberry**)
Please list the foods / medications they are allergic to and the reaction: _____
_____

MEDICATIONS (Please List Medications your child is currently taking)
_____

For Adolescent Female Patients:
YES / NO Is there any chance they may be **PREGNANT**?
YES / NO Are they taking **BIRTH CONTROL**?

****Signature of Parent / Guardian**:_____ **Date**: _____

For Office Use Only

Dentist's Review: _____
_____

Front:_____ _____ _____ _____ _____ _____
Asst:_____ _____ _____ _____ _____ _____

I certify there have been no changes in my child's medical history as given above: _____ _____
Signature of Parent or Guardian Date

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