MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Health issues and/or medications have a critical interaction(s) with dental treatment. Please answer the following questions about **YOUR CHILD**:

Name of primary physician? _____Phone Number _____

Is your child up to date with all immunizations? Yes No _____

Has ever been hospitalized or had a major surgery? Yes No If yes, please explain: _____

Has had any complication with Anesthesia Yes No _____

Has had a serious head or neck injury? Yes No If yes, please explain: _____

Is taking any prescription medications? Yes No If yes, please explain: _____

_____

Is taking herbal supplements or other medications/drugs? Yes No Provide a list: _____

Is on a special diet? (Ex: gluten free) Yes No _____

Needs antibiotic coverage before dental treatment? Yes No _____

History of developmental problems and/or syndromes: _____

History of learning disabilities: _____

Birth defects or Genetic Disorders: _____

Is allergic to the following Medications: _____

Other Allergies: _____

Has been diagnosed with any of the following?

ADHD/ADD	Yes	No	Autism spectrum	Yes	No	AIDS/HIV Positive	Yes	No
Diabetes	Yes	No	Hepatitis A, C or B (mark)	Yes	No	Kidney Problems	Yes	No
Cerebral palsy	Yes	No	Hearing loss	Yes	No	Epilepsy	Yes	No
Heart Murmur	Yes	No	Congenital Heart Disorder	Yes	No	Seizures	Yes	No
Bleeding disorder	Yes	No	Rheumatoid Arthritis	Yes	No	Anemia	Yes	No
Asthma	Yes	No	MRSA	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No						

Has ever been diagnosed with any serious illness not listed above? Yes No If yes, please explain: _____

_____

Comments: _____

For Patients 13 Years and Over:

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Are you taking Birth control? Yes No

Are you pregnant? Yes No

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 PATIENT, PARENT, or GUARDIAN_____ **DATE** _____**Patient Weight**_____

Parent Initials_____ Date_____ Patient Weight _____Staff Initials_____

Parent Initials_____ Date_____ Patient Weight _____Staff Initials_____

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