MEDICAL HISTORY

Patient's Name____Nickname________________ Sex: Male ◯ Female ◯
Birthdate______________________________Patient's Weight_________lbs (**for office use only** ____________________________)
Is this your child's first visit to the dentist? ◯ NO ◯ YES Reason for dental visit____
Has your child had an unfavorable reaction to medical/dental treatment? ◯ NO ◯ YES Please Explain:______________________________
____

Is your child in good health? ◯ NO ◯ YES **Is your child taking any medication or drugs now?** ◯ NO ◯ YES
LIST:____
Does your child have a physical/mental disability? ◯ NO ◯ YES Explain:____
Did/does your child have a baby bottle at nap and/or bedtime? ◯ NO ◯ YES How long?____
Does your child have a finger habit? ◯ NO ◯ YES **EXPLAIN**:________________________Does your child still use a pacifier? ◯ NO ◯ YES
Under physicians care now? ◯ NO ◯ YES **EXPLAIN**:____
Has child ever been hospitalized or had a major operation or surgery? ◯ NO ◯ YES **EXPLAIN**: __________________________________
____
Has your child ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosonates? ◯ NO ◯ YES
Is your child on a special diet? ◯ NO ◯ YES **EXPLAIN:** ____
Does your child smoke or chew tobacco? ◯ NO ◯ YES Does anyone in the household smoke tobacco? ◯ NO ◯ YES
Does your child use controlled substances? ◯ NO ◯ YES **EXPLAIN**: ____
Is your child allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal
□ Latex □ Sulfa □ Other Explain:____
IS your child up to date on immunizations against childhood diseases? ◯ NO ◯ YES

Is your child pregnant? ◯ NO ◯ YES Is your child taking oral contraceptives? ◯ NO ◯ YES Nursing? ◯ NO ◯ YES

Does your child have, or ever had, any of the following? For each YES please provide details in the comments at the bottom of the list.

	Y	N		Y	N		Y	N		Y	N
Abuse or Neglect			Diabetes			Herpes			Psychiatric Care		
ADD/ADHD			Drug Addiction			High Blood Pressure			Radiation Treatment		
AIDS/HIV Positive			Ear Infections			High Cholesterol			Recent Weight Loss		
Anaphylaxis			Easily Winded			Hormonal Dysfunction			Renal Dialysis		
Anemia			Eating Disorder			Hydrocephaly			Rheumatic Fever		
Angina			Eczema/Rash/Hives			Hypoglycemia			Rheumatism		
Arthritis/Gout			Epilepsy/Seizures			Irregular Heartbeat			Scarlet Fever		
Artificial Valves/Joints			Excessive Bleeding			Kidney Problems			Sensory Processing		
Asthma/RAD			Excessive Thirst			Leukemia			Sickle Cell Disease		
Autism Spectrum			Fainting/Dizziness			Liver Disease			Sinus Trouble		
Bleeding Disorders			Frequent Cough			Low Blood Pressure			Spina Bifida		
Blood Transfusion			Frequent Diarrhea			Lung Disease			Sleep Apnea/Snoring		
Breathing Problem			Frequent Headaches			Measles			Stroke		
Bruise Easily			GERD			Mitral Valve Prolapse			Thyroid Disease		
Cancer			Glaucoma			MRSA			Tonsillitis		
Cerebral Palsy			Hearing Loss			Mumps			Tuberculosis		
Chest Pains			Heart Failure			Pacemaker			Tumors/Growths		
Chicken Pox			Heart Murmur			Parathyroid Disease			Ulcers		
Cold Sores/Blisters			Heart Disease			Pain in Jaw Joints			Venereal Disease		
Cystic Fibrosis			Hemophilia			Pneumonia			Vision Impairment		
Developmental Delays			Hepatitis A, B, or C			Prematurity			Yellow Jaundice		

Has your child ever had any serious illness not listed above? ◯ **NO** ◯ **YES** ____
Comments:____
____
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**_______________________