MEDICAL HISTORY

Patient's Name _____

Has your child ever had any of the following conditions??

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia/Low Blood Count	☐	☐	Hearing Impairments	☐	☐	Cystic Fibrosis
☐	☐	Heart Condition	☐	☐	Kidney Disease or Transplant	☐	☐	Blindness
☐	☐	Rheumatic/Scarlet Fever	☐	☐	Hepatitis or Liver Disease	☐	☐	Other Conditions:
☐	☐	Cancer, Malignancies or Leukemia	☐	☐	Child Abuse			_____
☐	☐	Asthma	☐	☐	Infection			
☐	☐	Diabetes	☐	☐	Cleft Lip/Palate			
☐	☐	Epilepsy, Seizures or Convulsions	☐	☐	Cerebral Palsy			
☐	☐	Hyperactivity/ADD	☐	☐	Birth Defects			
☐	☐	Psychiatric Care	☐	☐	Developmentally Delayed			
☐	☐	Latex Allergy or Sensitivity	☐	☐	Tuberculosis or Previous Positive Test			
☐	☐	Pain in Jaw Joints	☐	☐	Autism			
☐	☐	Excessive Bleeding/Hemophilia	☐	☐	Food Allergies? To what? Especially eggs. _____			

☐ ☐ Is Pre-Med necessary due to a heart condition or other medical reason?

☐ ☐ Is the patient currently taking any medication(s)? (If yes, please list)

_____

☐ ☐ Is the patient currently under the care of a physician? (If yes, for what?)

_____

☐ ☐ Is your child allergic or has your child ever had an adverse reaction to a specific medication? (If yes, which?)

_____

PLEASE LIST ANY TREATING DOCTOR (I.E. PEDIATRICIAN)

Type Of Doctor_____ Name _____ Office Phone _____

DENTAL HISTORY

Has your child ever suffered from any of the following conditions?

Yes	No		Yes	No	
☐	☐	Bad Breath/Halitosis	☐	☐	Dental Infection or Abscess
☐	☐	Bleeding Gums	☐	☐	Recent Dental Pain
☐	☐	Stained and Discolored Teeth	☐	☐	Missing or Extra Teeth
☐	☐	Cold Sores or Fever Blisters	☐	☐	Thumb/Finger Sucking
☐	☐	Dry Mouth	☐	☐	Dental Grinding/Clenching

☐ ☐ Do you wish to talk to the doctor privately about any special concerns?

☐ ☐ Has your child experienced any unfavorable reaction from previous medical or dental care? (If yes, please explain)

_____

☐ ☐ Injury or Trauma to Teeth, Mouth or Face (If yes, please explain)

_____

☐ ☐ Does your child receive fluoride supplementation from vitamins, water or tablet/drops?

How do you think your child will act toward the dentist?

☐ Cooperative ☐ Fearful ☐ Defiant ☐ Don't know

Parent/Legal Guardian Signature _____ Date _____