Child's Medical History

Physician's Name: _____

Clinic name: _____ Date of last visit: _____

Is your child currently under the care of a physician? Yes No

Please explain:

_____

Do they require antibiotics before dental work? Yes No

Have they ever been treated for osteoporosis or bone cancer? Yes No

Does your child drink city water (vs. well or bottles water)? Yes No

Are you interested in your child having braces? Yes No

Are they taking any prescription or over the counter drugs? Yes No

Please list each one:

_____

_____

Please list any allergies:

_____

_____

_____

Does your child have any of the following habits? Please circle all that apply:

- Thumb/Finger Sucking
- Lip sucking/biting
- Nail biting
- Nursing bottle habits

Please circle if your child has or has had the following:

- Abnormal Bleeding
- Alcohol Abuse
- Anemia
- Arthritis
- Artificial Joints- when? _____
- Artificial Heart Valves
- Asthma
- Cancer/Chemotherapy/Radiation Type_____ when? ____
- Colitis
- Diabetes
- Congenital Heart Defect- corrected? Yes No
- Difficulty breathing
- Drug Abuse
- Eating Disorder
- Emphysema
- Epilepsy/Seizures
- Fainting Spells
- Frequent Headaches
- Glaucoma
- Hemophilia
- Heart Attack- when? _____
- High Blood Pressure
- Heart Murmur (Rheumatic Fever/Scarlet Fever)
- High Cholesterol
- Heart Surgery- when? _____
- HIV / AIDS
- Hepatitis- Type? _____
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Pacemaker- when? _____
- Persistent Cough
- Pregnant/Nursing- due: _____
- Psychiatric Problems
- Sickle Cell Disease/Traits
- Sinus Problems
- Steroid Therapy
- Autoimmune Disease (MS, Lupus, Rheumatoid Arthritis, Sjogrens, etc)
- Stroke- when? _____
- Tobacco use - interested in quitting? Yes No
- Thyroid Problems
- Tuberculosis (TB) - when? _____
- Ulcers

Please list any serious medical condition(s) that your child has experienced:

_____

_____

_____

_____

_____

Child's Legal Guardians (authorized to make treatment decisions):

I understand that the health information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform any necessary dental services that I may need with my informed consent during diagnosis and treatment.

_____ _____/_____/ 20_____

Signature Date

Update:

Initial: _____Date: _____

Initial: _____Date: _____

Initial: _____Date: _____

Initial: _____Date: _____

In the event of an emergency is there someone who lives near you we should contact?

Their Name: _____

Relationship: _____

Wk#: (_____) _____

HM/Cell#: (_____) _____