MEDICAL HISTORY

Child's Name: ______________ Nick Name: ________ Age: ____ DOB: ___ /___ /_____ ☐ Male ☐ Female | ☐ He/Him ☐ She/Her

Parent/Guardian: ______________ DOB: ___ /___ /_____ Parent/Guardian: ______________ DOB: ___ /___ /_____

Address: ______________ City: ______________ Zip: ________

Cell Phone: (______) ______________ Alt Phone: (______) ______________ Home Phone: (______) ______________

Email Address: ______________ How did you hear about us? ______________

Who is your Pediatrician? ______________ Phone: (______) ______________

Do any of the following apply to your child? *MARK YES or NO for every single one.* (☑ OR ☒ to mark choice)

BLOOD CONDITIONS

- ☐ YES ☐ NO Hypoglycemia
- ☐ YES ☐ NO Prolonged/Abnormal Bleeding
- ☐ YES ☐ NO Bruises Easily
- ☐ YES ☐ NO Sickle Cell Anemia/Trait
- ☐ YES ☐ NO Hemophilia

Other ______________

RESPIRATORY SYSTEM AND LUNG CONDITIONS

- ☐ YES ☐ NO Sleep Apnea
- ☐ YES ☐ NO Tuberculosis (TB)
- ☐ YES ☐ NO Asthma

If YES for Asthma, what triggers an attack?

☐ Allergies ☐ Exercise/Exertion ☐ Stress

Are you on Medication to treat Asthma?

☐ Albuterol ☐ Nebulizer ☐ Steroids

☐ No Medications

- ☐ YES ☐ NO Have you ever been to the Emergency Room for an attack?

How many times in the past 3 years? ________

Other ______________

INTELLECTUAL OR DEVELOPMENTAL CONDITIONS

- ☐ YES ☐ NO ADD/ADHD
- ☐ YES ☐ NO Autism
- ☐ YES ☐ NO Downs Syndrome
- ☐ YES ☐ NO Cerebral Palsy

Other ______________

CONGENITAL OR PHYSICAL CONDITIONS

- ☐ YES ☐ NO Cleft Lip / Cleft Palate
  Surgery? ________ ☐ YES ☐ NO
- ☐ YES ☐ NO Spina Bifida

Other ______________

MENTAL HEALTH CONDITIONS

- ☐ YES ☐ NO Has had Psychiatric Care

Other ______________

IMMUNE SYSTEM CONDITIONS

- ☐ YES ☐ NO HIV Positive/AIDS
- ☐ YES ☐ NO Juvenile Rheumatoid Arthritis
- ☐ YES ☐ NO Cancer
- ☐ YES ☐ NO Chemotherapy
- ☐ YES ☐ NO Leukemia
- ☐ YES ☐ NO Radiation Treatment
- ☐ YES ☐ NO Autoimmune Disease

If YES, please specify ______________

Other ______________

OTHER CONDITIONS

- ☐ YES ☐ NO Diabetes TYPE 1 or 2
- ☐ YES ☐ NO Kidney Diagnosis
- ☐ YES ☐ NO Seizure Disorder/Epilepsy
- ☐ YES ☐ NO Stomach/Liver Diagnosis
- ☐ YES ☐ NO Hepatitis A, B, C
- ☐ YES ☐ NO Hearing Impaired
- ☐ YES ☐ NO Speech Impaired
- ☐ YES ☐ NO Jaw Difficulty: TMJ

Other ______________

MAJOR SURGERIES OR PROCEDURES

- ☐ YES ☐ NO Shunt Placed
- ☐ YES ☐ NO Organ Transplant
- ☐ YES ☐ NO Blood Transfusion

Other ______________

HEART CONDITIONS

- ☐ YES ☐ NO Open Heart Surgery
- ☐ YES ☐ NO Congenital Heart Defect
- ☐ YES ☐ NO Mitral Valve Prolapse
- ☐ YES ☐ NO Irregular Heart Beat
- ☐ YES ☐ NO Patient Ductus Arteriosus (PDA)
- ☐ YES ☐ NO Prolonged Q-T Interval
- ☐ YES ☐ NO Rheumatic Fever
- ☐ YES ☐ NO Arterial Septal Defect (ASD)
- ☐ YES ☐ NO Ventricular Septal Defect (VSD)
- ☐ YES ☐ NO Kawasaki Disease
- ☐ YES ☐ NO Heart Murmur
  If YES, is it innocent? ☐ YES ☐ NO
- ☐ YES ☐ NO Has your child ever been told to take antibiotics before dental treatment?

If any are YES, who is your Cardiologist?

Name: ______________

Phone: (______) ______________

FOR FEMALE PATIENTS

- ☐ YES ☐ NO Is the patient currently Pregnant?
- ☐ YES ☐ NO Is the patient taking Birth Control Pills?

PLEASE LIST MEDICATIONS

____

____

ALLERGIES			*TYPE OF REACTION*			
☐ YES	☐ NO	Amoxicillin / Penicillin . .	☐ Rash/Hives	☐ Trouble Breathing	☐ Diarrhea	☐ Anaphylactic
☐ YES	☐ NO	Augumentin.	☐ Rash/Hives	☐ Trouble Breathing	☐ Diarrhea	☐ Anaphylactic
☐ YES	☐ NO	Cephalasporin / Keflex . .	☐ Rash/Hives	☐ Trouble Breathing	☐ Diarrhea	☐ Anaphylactic
☐ YES	☐ NO	Codeine	☐ Rash/Hives	☐ Trouble Breathing	☐ Diarrhea	☐ Anaphylactic
☐ YES	☐ NO	Erythromycin	☐ Rash/Hives	☐ Trouble Breathing	☐ Diarrhea	☐ Anaphylactic
☐ YES	☐ NO	Latex	☐ Rash/Hives	☐ Trouble Breathing	☐ Diarrhea	☐ Anaphylactic
☐ YES	☐ NO	Sulfa	☐ Rash/Hives	☐ Trouble Breathing	☐ Diarrhea	☐ Anaphylactic
Other ______________			☐ Rash/Hives	☐ Trouble Breathing	☐ Diarrhea	☐ Anaphylactic

Is there anything else you want the doctor to know about? ______________

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: ___ /___ /_____