MEDICAL HISTORY

Child's Name:_____ Age_____ Date of Birth_____ ☐ Male ☐ Female

Parent/Legal Guardian's Name:_____

Address: _____City_____Zip Code_____

Cell Phone _____ Home Phone _____ Work Phone_____

How did you hear about our office?_____

What is your e-mail address? _____

Do any of the following apply to your child? **(CIRCLE YES OR NO for every single one, no big circle for multiple)**

YES	NO	ADD/ ADHD	YES	NO	Shunt	YES	NO	Prolonged/ Abnormal bleeding
YES	NO	Autism	YES	NO	Sleep Apnea	YES	NO	Bruise Easily
YES	NO	Birth Defects	YES	NO	HIV positive/ AIDS	YES	NO	Blood Transfusion
YES	NO	Mental Retardation	YES	NO	Hypoglycemia	YES	NO	Sickle Cell Anemia/Trait
YES	NO	Downs Syndrome	YES	NO	Jaw difficulty: TMJ	YES	NO	Hemophilia
YES	NO	Cerebral Palsy	YES	NO	Juvenile Rheumatoid Arthritis	YES	NO	Hepatitis A, B, C
YES	NO	Cleft Lip or Palate	YES	NO	Psychiatric Care	YES	NO	Speech or hearing problems
YES	NO	Diabetes TYPE 1 OR 2	YES	NO	Tuberculosis (TB)	YES	NO	Spina Bifida
YES	NO	Kidney Problems	YES	NO	Organ Transplant	YES	NO	Stomach/Liver Problems
YES	NO	Handicaps/Disabilities	YES	NO	Seizure Disorder/Epilepsy			

LUNGS

YES NO Asthma

If YES for Asthma what triggers an attack? **(circle one)**

Allergies Exercise / Exertion Stress

YES NO Medications used to treat **(circle one)**

Albuterol Nebulizer Steroids No Medications

Other medication (list here) _____

YES NO Ever been to the Emergency Room for an attack?

If YES how many times in the past 3 years? _____

CANCER

YES NO Cancer
YES NO Chemotherapy
YES NO Leukemia
YES NO Radiation Treatment

If YES which type of cancer?

_____

ALLERGIES

			Type of reaction			
YES	NO	Amoxicillin / Penicillin	Rash/Hives	Trouble breathing	Diarrhea	Anaphylactic
YES	NO	Augmentin	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

HEART

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

If YES who is cardiologist?

Name _____

Phone_____

Who is your Pediatrician?

Name_____

Phone_____

ADOLESCENT **FEMALE PATIENTS**

YES NO Is the patient PREGNANT ?

YES NO Is the patient taking BIRTH CONTROL PILLS?

List any other problems / hospitalizations your child has had:

_____

_____

List any other medications being taken:_____

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_____