MEDICAL HISTORY

Child's Full Name: ________________ Nickname: __________ Date of birth: _____/_____/________

Gender: ☐ M ☐ F Height : __________ Weight: __________ Date of last physical exam: _____/_____/________

Name/address/phone of primary physician: ________________________________

Name/address/phone of medical specialists: ________________________________

Is your child being treated by a physician at this time? Reason ________________ ☐ YES ☐ NO

Is your child taking any medications (prescription or over the counter), vitamins, or supplements? ☐ YES ☐ NO

List name, dose, frequency & date started: ________________________________

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Has your child ever been hospitalized, had surgery, or been treated in the ER? ☐ YES ☐ NO

List date & describe: ________________________________

Has your child ever had a problem with an anesthetic? Describe ________________ ☐ YES ☐ NO

Has your child ever had a reaction or allergy to an antibiotic or medication? List: ________________ ☐ YES ☐ NO

Is your child allergic to latex or anything else such as metals, acrylic, etc.? List: ________________ ☐ YES ☐ NO

Is your child up to date on immunizations against childhood diseases? ☐ YES ☐ NO

Please mark YES or NO if your child has or has ever had any of the following conditions:

Condition			Condition		
Abnormal bleeding/Hemophilia	☐ YES	☐ NO	Heart Murmur	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Hepatitis / Liver Problems	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Hydrocephaly / Shunt Placement	☐ YES	☐ NO
Autism	☐ YES	☐ NO	Hypertension	☐ YES	☐ NO
Complications at birth	☐ YES	☐ NO	HIV/ AIDS	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Kidney / Bladder Problems	☐ YES	☐ NO
Congenital Heart Defects	☐ YES	☐ NO	Neurological Disorders	☐ YES	☐ NO
Cystic Fibrosis	☐ YES	☐ NO	Pneumonia	☐ YES	☐ NO
Developmental Disorders	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
Gastroesophageal / Acid Reflex	☐ YES	☐ NO	Sinus Problems	☐ YES	☐ NO

Provide details or list any other conditions not listed above:

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Dental History

Has your child ever had a bad experience at the dentist? Explain: ________________ ☐ YES ☐ NO

Has your child ever had a thumb/finger sucking habit? ☐ YES ☐ NO

Has your child ever experienced any tooth pain? ☐ YES ☐ NO

Is your child currently experiencing any tooth pain? ☐ YES ☐ NO

Has your child ever had any facial/mouth trauma? Explain: ________________ ☐ YES ☐ NO

Do you help your child brush and floss? ☐ YES ☐ NO

Does your child use a mouth rinse? What kind: ________________ ☐ YES ☐ NO

Does your child brush? How often: ________________ ☐ YES ☐ NO

Does your child floss? How often: ________________ ☐ YES ☐ NO

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Parent or Legal Guardian's Signature Date