MEDICAL HISTORY

Fax

Child's Physician | City | Phone Number

Date of last Physical exam

Is your child presently under the care of a physician for any medical problem? ☐ YES ☐ NO

If so, for what problem?

Is your child currently taking any medication? ☐ YES ☐ NO

Medicine | Dosage

Has there been any changes in his/her health within the past year? ☐ YES ☐ NO

Does your child bruise easily? ☐ YES ☐ NO

Is your child sensitive or allergic to any drugs (e.g. penicillin)? ☐ YES ☐ NO

Does your child have a history of allergies? ☐ YES ☐ NO

Has your child ever been hospitalized or had surgery? ☐ YES ☐ NO

If yes, please explain ____________

Reason? | Date

Has your child ever had blood transfusions? ☐ YES ☐ NO

If so, for what reason and when?

Is your child emotionally disturbed, developmentally delayed, handicapped, or have a learning disability? ☐ YES ☐ NO

Please indicate if your child has had a history of the following.

Condition		Condition		Condition	
Heart trouble or murmur	☐ YES ☐ NO	Epilepsy	☐ YES ☐ NO	Learning problems	☐ YES ☐ NO
Rheumatic fever	☐ YES ☐ NO	Kidney/Bladder Problems	☐ YES ☐ NO	Behavior problems	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Hepatitis or Jaundice	☐ YES ☐ NO	Ulcers or stomach pain	☐ YES ☐ NO
Tuberculosis	☐ YES ☐ NO	Stroke	☐ YES ☐ NO	Seizure disorder	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Head or neck pain	☐ YES ☐ NO	Neurological problems	☐ YES ☐ NO
Arthritis or joint disease	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	HIV Virus or AIDS	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Skin orders, Rashes, Hives	☐ YES ☐ NO	Hearing problems	☐ YES ☐ NO
Blood disorder	☐ YES ☐ NO	Respiratory problems	☐ YES ☐ NO	Sight problems	☐ YES ☐ NO
Bone disorder	☐ YES ☐ NO	Bleeding problems	☐ YES ☐ NO	Trauma	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Mental retardation	☐ YES ☐ NO	Convulsions	☐ YES ☐ NO
Congenital birth defects	☐ YES ☐ NO	Developmental delays	☐ YES ☐ NO	Thyroid problems	☐ YES ☐ NO

Any other conditions or problems that the doctor should be aware of?

DENTAL HISTORY

Is this your child's first dental visit? ☐ YES ☐ NO

Previous Dentist | City | Date of last visit

Has your child had an unfavorable experience at another office? ☐ YES ☐ NO

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

Times per day your child brushes his/her teeth?

Dental floss used? ☐ YES ☐ NO

Is flouride taken in any form? (water, tablets, etc.) ☐ YES ☐ NO

Does your child have a history of any of the following: ☐ Finger sucking ☐ Lip sucking ☐ Nail biting ☐ Pacifier

How old was your child when he/she discontinued bottle use or nursing?

Does your child have a problem with his/her bite? ☐ YES ☐ NO

I hereby state that the above information is true and correct

Relation to child

Print name | Signature | Date