



YOUR CHILD'S MEDICAL HISTORY

Your Child's name _____ Nickname _____ Date _____

Birth Date _____ Medical Alert _____

Your Child's Physician: Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

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

If yes, please describe _____

Is your child taking any medications? (prescription or over-the-counter)..... Yes No

If yes, please describe _____

Have you ever been told your child needs antibiotics or premeds before treatment? Yes No

Does your child have an allergic (or adverse) reaction to any medication or other substance?.. Yes No

If yes, please list _____

Are your child's immunizations current? Yes No

List any Hospitalizations, Surgeries, Serious Illnesses

When?

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

- | | | |
|--|--|---|
| AIDS/HIV positive..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital heart disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung problem..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies or Hives..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles/Mumps..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Handicaps/Disabilities..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous disorders..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Behavioral/Learning disorder. <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Psychological... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing problem..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic/Scarlet fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Brain Injury..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart condition..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle cell anemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A B C (circle)..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach problem..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cerebral palsy..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/Liver problem..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken pox..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex sensitivity..... <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Other?..... Yes No Please specify _____

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Signature of Parent/Guardian _____ **Date** _____