Child Medical History

First Name: _____ Last Name: _____DOB: ____/____/____

What is the reason for seeking dental care? ❑ Checkup/cleaning for routine care ❑ Dental care for a specific problem
Explain: _____

Has your child had dental care/seen a dentist before? ❑ Yes ❑ No

Name of previous dentist: _____ Date of last dental visit: _____

Any issued with previous dental visits? ❑ Yes ❑ No If so, please explain: _____

Are they under the care of a physician now or see one for routine care? ❑ Yes ❑ No

Does your child have any of the following?
(Please check/circle any that apply)

- ❑ Abnormal/prolonged bleeding following injuries
- ❑ ADD / ADHD (circle)
- ❑ AIDS / HIV positive (circle)
- ❑ Anemia or blood disorders
- ❑ Anxiety, emotional condition, nervous breakdowns (circle):
  _____
- ❑ Artificial joint, date & type:
  _____
- ❑ Artificial valve
- ❑ Asthma, breathing problems shortness of breath (circle)
- ❑ Autism/ Autism Spectrum (circle)
- ❑ Blood disorder
- ❑ Cancer or tumor, explain:
  _____
- ❑ Cold Sores
- ❑ Diabetes = **Type I or II** _____
- ❑ Epilepsy, seizures, or fainting spells (circle)
- ❑ Hay fever or sinus trouble (circle)
- ❑ Headaches, back aches, neck aches (circle)
- ❑ Heart murmur, mitral valve prolapse, heart defect (circle)
- ❑ Hepatitis A, B, C (circle)
- ❑ Herpes or cold sores (circle)
- ❑ Hospitalizations in the last 5 years, reason:
  _____
- ❑ Liver disease (jaundice, cirrhosis or other)
- ❑ Kidney disease
- ❑ Neurologic condition
- ❑ Radiation or chemo treatment
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Seasonal Allergies
- ❑ Stroke, date: _____
- ❑ Thyroid Condition
- ❑ Tuberculosis or other lung problems

Do you have any limitations on diet or activity? _____

_____

Are they allergic to, or have you reacted adversely to any of the following?

- ❑ Latex ❑ Sulfa drugs ❑ Other Antibiotic ❑ Aspirin
- ❑ Codeine, Vicodin or another narcotic (circle)
- ❑ Barbiturates, sedatives or sleeping pills (circle)
- ❑ Penicillin/ Amoxicillin
- ❑ Other: _____
  _____

Does your child do any of the following:

- ❑ Suck their thumb
- ❑ Drink out of a bottle

How often does your child do the following?

Brush their teeth: _____ Floss their teeth: _____

Are they taking any medications, vitamin or supplements?
Please list ALL medications/supplements you are taking;

_____
_____
_____
_____
_____

Do they have any other condition, disease or problem not listed above?

_____
_____
_____

To the best of my knowledge, the answers 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.

_____

Patient/Guardian Signature

_____

Date