



Medical History

Date: _____

CHILD'S PHYSICIAN NAME _____

ADDRESS _____

• Is your child presently under the care of a specialist for any medical reason? If yes, what? Yes No _____

SPECIALIST NAME _____ PHONE NUMBER _____

• Does your child have a history of health problems? If yes, explain: Yes No _____

• Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt or other medical reason? Yes No

• Is your child presently taking any medications? Type and Dose: Yes No _____

• Has your child had a history of taking medications frequently? Yes No

• Has your child ever been hospitalized or had surgery? For what? Yes No _____

• Is your child allergic to any drugs or medications? If yes, what? Yes No _____

Is your child allergic to any latex, metals, or acrylics? If yes, what? Yes No _____

Does your child have any other allergies? If yes, what? Yes No _____

Has any member of the family, including your child, had a problem with general anesthetic? Yes No

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO.

- Yes No AIDS - HIV - STD's
- Yes No Anemia, Hemophilia, Bleeding Disorders
- Yes No Asthma, Cystic Fibrosis, Respiratory Diseases
- Yes No Autism
- Yes No Blood Disease
- Yes No Blood Transfusions
- Yes No Birth Defects
- Yes No Bone or Joint Problems, Arthritis
- Yes No Brain Injury
- Yes No Bruising Easily
- Yes No Cancer or Malignancies
- Yes No Chemotherapy, Radiation
- Yes No Child Abuse
- Yes No Chronic Adenoid/Tonsil Infection
- Yes No Cleft Lip/Palate
- Yes No Congenital Heart Lesion
- Yes No Diabetes, Thyroid, or Endocrine Disease
- Yes No Emotional Disturbance
- Yes No Neurological Disease, Cerebral Palsy
- Yes No Eye Problems
- Yes No Excessive Bleeding Problems
- Yes No Excessive Gagging
- Yes No Fainting or Dizziness
- Yes No Growth & Developmental Problems
- Yes No Heart Surgery
- Yes No Headaches
- Yes No Hearing/Speech Impairments
- Yes No Heart Murmur, Defect, Congenital Heart Disease
- Yes No Hepatitis or Liver Disease
- Yes No Hyperactivity/ADD
- Yes No Kidney Disease, Bladder Problems
- Yes No Mental or Developmental Delay
- Yes No Mouth Sores
- Yes No Pain in Jaw Joints
- Yes No Psychiatric Care
- Yes No Rheumatic Fever
- Yes No Sickle Cell Anemia or Trait
- Yes No Syndrome _____
- Yes No Other _____
- Yes No Do you wish to talk to the doctor privately about a special concern?

Is this your child's first dental visit? Yes No

PREVIOUS DENTIST _____ CITY _____

DATE OF LAST VISIT _____

Any injuries to your child's teeth or jaws? When? Yes No _____

History of: _____ When? _____

- Nursing bottle habits _____
- Thumb sucking/Finger sucking _____
- Pacifier _____
- Teeth grinding or clenching _____

Has your child experienced any unfavorable reaction from previous medical or dental care? Yes No (If yes, please explain)

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

Has your child had recent dental pain?

Doctor's Notes: _____

Parent Signature _____ Date _____