KidstoothDoc

MEDICAL HISTORY

Patient's Name_____Nickname_____ Sex: Male ◯ Female ◯
Birthdate_____Patient's Weight_____lbs (**for office use only** _____)
Reason for dental visit:_____ Is this your child's first visit? ◯ YES ◯ NO
Has your child had an unfavorable reaction to medical/dental treatment? ◯ YES ◯ NO Please Explain:_____
_____
Is your child in good health? ◯ YES ◯ NO Is your child taking any medication or drugs now? List: _____
_____
Does your child have a physical/mental disability? ◯ NO ◯ YES Explain:_____
Did/does your child have a baby bottle at nap and/or bedtime? ◯ YES ◯ NO How long?_____
Does your child have a finger habit? ◯ YES ◯ NO Does your child still use a pacifier? ◯ YES ◯ NO
Under physicians care now? ◯ NO ◯ YES Explain:_____
Has child ever been hospitalized or had a major operation? ◯ NO ◯ YES Explain: _____
Does your child take, or have taken, Phen-Fen or Redux? ◯ NO ◯ YES
Has your child ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosonates? ◯ YES ◯ NO
Is your child on a special diet? ◯ YES ◯ NO Does your child use tobacco or chew? ◯ YES ◯ NO
Does your child use controlled substances? ◯ YES ◯ NO
Is your child pregnant? ◯ YES ◯ NO Is your child taking oral contraceptives? ◯ YES ◯ NO Nursing? ◯ YES ◯ No
Is your child allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal
□ Latex □ Sulfa □ Other Explain:_____

Has your child have, or ever had, any of the following?

	Y	N		Y	N		Y	N		Y	N
Aids/HIV Positive			Drug Addiction			High Blood Pressure			Radiation Treatment		
Alzheimer's			Ear Infections			High Cholesterol			Recent Weight Loss		
Anaphylaxis			Easily Winded			Hives or Rash			Renal Dialysis		
Anemia			Emphysema			Hormonal Dysfunction			Rheumatic Fever		
Angina			Epilepsy/Seizures			Hypoglycemia			Rheumatism		
Arthritis/Gout			Excessive Bleeding			Irregular Heartbeat			Scarlet Fever		
Artificial Heart Valve			Excessive Thirst			Kidney Problems			Shingles		
Artificial Joint			Fainting/Dizziness			Leukemia			Sickle Cell Disease		
Asthma			Frequent Cough			Liver Disease			Sinus Trouble		
Blood Disease			Frequent Diarrhea			Low Blood Pressure			Spina Bifida		
Blood Transfusion			Frequent Headaches			Lung Disease			Stomach Disease		
Breathing Problem			Genital Herpes			Measles			Stroke		
Bruise Easily			Glaucoma			Mitral Valve Prolapse			Swelling of Limbs		
Cancer			Hay Fever			Mumps			Thyroid Disease		
Chemotherapy			Heart Attack/Failure			Osteoporosis			Tonsilitis		
Chest Pains			Heart Murmur			Pacemaker			Tuberculosis		
Chicken Pox			Heart Disease			Parathyroid Disease			Tumors/Growths		
Cold Sores/Blisters			Hemophilia			Pain in Jaw Joints			Ulcers		
Convulsions			Hepatitis A			Pneumonia			Venereal Disease		
Cortisone Medicine			Hepatits B or C			Psychiatric Care			Yellow Jaundice		
Diabetes			Herpes								

Has your child ever had any serious illness not listed above? ◯ Yes ◯ No _____
Comments:_____

To the best of my knowledge, the questions 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.

SIGNATURE OF PARENT OR GUARDIAN_____**DATE**_____