

**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			Tonsillitis		
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			Hepatitis 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 \_\_\_\_\_