KidstoothDoc

MEDICAL HISTORY

Patient's Name_____Nickname_____ Sex: Male ◯ Female ◯
Birthdate_____Patient's Weight_____lbs (**for office use only** _____)
Is this your child's first visit to the dentist? ◯ NO ◯ YES Reason for dental visit_____
Has your child had an unfavorable reaction to medical/dental treatment? ◯ NO ◯ YES Please Explain:_____
_____
Is your child in good health? ◯ NO ◯ YES **Is your child taking any medication or drugs now?** ◯ NO ◯ YES
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? ◯ NO ◯ YES How long?_____
Does your child have a finger habit? ◯ NO ◯ YES **EXPLAIN**:_____Does your child still use a pacifier? ◯ NO ◯ YES
Under physicians care now? ◯ NO ◯ YES **EXPLAIN**:_____
Has child ever been hospitalized or had a major operation or surgery? ◯ NO ◯ YES **EXPLAIN**: _____
_____
Has your child ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosonates? ◯ NO ◯ YES
Is your child on a special diet? ◯ NO ◯ YES **EXPLAIN:** _____
Does your child smoke or chew tobacco? ◯ NO ◯ YES Does anyone in the household smoke tobacco? ◯ NO ◯ YES
Does your child use controlled substances? ◯ NO ◯ YES **EXPLAIN**: _____
Is your child allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal
□ Latex □ Sulfa □ Other Explain:_____
IS your child up to date on immunizations against childhood diseases? ◯ NO ◯ YES

Is your child pregnant? ◯ NO ◯ YES Is your child taking oral contraceptives? ◯ NO ◯ YES Nursing? ◯ NO ◯ YES

Does your child have, or ever had, any of the following? **For each YES please provide details in the comments at the bottom of the list.**

	Y	N		Y	N		Y	N		Y	N
Abuse or Neglect			Cystic Fibrosis			Hemophilia			Prematurity (<36 weeks)		
ADD/ADHD			Developmental Delays			Hepatitis A, B or C			Psychiatric Care		
AIDS/HIV Positive			Diabetes			Herpes			Radiation/Chemo Treatment		
Anaphylaxis			Drug Addiction			High Blood Pressure			Recent Weight Loss		
Anemia			Ear Infections			High Cholesterol			Rheumatic Fever		
Angina			Easily Winded			Hormonal Dysfunction			Rheumatism		
Anxiety/Depression			Eating Disorder			Hydrocephaly			Scarlet Fever		
Arthritis/Gout			Eczema/Rash/Hives			Hypoglycemia			Sensory Processing		
Artificial Valves/Joints			Epilepsy/Seizures			Irregular Heartbeat			Sickle Cell Disease		
Asthma/RAD			Excessive Bleeding			Kidney/Bladder Problems			Sinus Trouble		
Autism Spectrum			Excessive Thirst			Leukemia			Spina Bifida		
Bleeding Disorders			Fainting/Dizziness			Liver Disease/Jaundice			Sleep Apnea/Snoring		
Blood Transfusion			Frequent Cough			Low Blood Pressure			Stomach/Intestine Problems		
Breathing Problems			Frequent Diarrhea			Lung Disease			Stroke		
Bruises Easily			Frequent Headaches			Measles/Mumps			Thyroid Disease		
Cancer			GERD/Reflux			Mitral Valve Prolapse			Tonsillitis		
Cerebral Palsy			Glaucoma			MRSA			Tuberculosis		
Chest Pains			Hearing/Vision Loss			Pacemaker			Tumors/Growths		
Chicken Pox			Heart Failure			Parathyroid Disease			Ulcers		
Cleft Lip/Palate			Heart Murmur/Defect			Pain in Jaw Joints			Venereal Disease		
Cold Sores/Blisters			Heart Disease			Pneumonia					

Has your child ever had any serious illness not listed above? ◯ NO ◯ YES _____
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**_____

SIGNATURE OF DOCTOR _____**DATE**_____