



MEDICAL HISTORY

Name _____ Nickname _____ Birthdate _____ Boy ☐ Girl ☐

Brothers, Sisters _____

MEDICAL INFORMATION

Child's Physician _____ Phone # _____

Is your child taking any medications? Yes ☐ No ☐ Please list _____

Does your child have any allergies or drug sensitivities? Yes ☐ No ☐ Please describe _____

Has your child ever been hospitalized, have surgery or been treated in an emergency department?

Please check any of the following conditions for which your child has been treated

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Autism/Autism spectrum disorder |
| <input type="checkbox"/> Bleeding Disorder/Anemia/sickle cell | <input type="checkbox"/> Behavioral, emotional problems |
| <input type="checkbox"/> Heart Disorder/Defect | <input type="checkbox"/> Abuse or neglect |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Developmental disorders, learning problems/delays |
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Speech/Hearing Problems |
| <input type="checkbox"/> Liver/ Kidney Problems | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer/Tumor/Chemotherapy/Radiation Therapy |
| <input type="checkbox"/> Epilepsy/Seizures | |
| <input type="checkbox"/> Nutritional Problems/GERD | |

Please describe any medical concerns your child has _____

DENTAL INFORMATION

Is there family history of cavities? _____

Please describe your main concern about your child's dental health _____

Has your child had a negative experience in the past with a dentist or physician? Please explain _____

Former Dentist _____

Phone _____

Address _____

Date of last dental care _____

Date of last x-ray _____

How often does your child brush? _____

Floss? _____

Does your child experience pain or discomfort in the jaw joint? ☐Yes ☐No

Has your child experience a mouth or chin injury? ☐Yes ☐No

Does your child have speech problems? ☐Yes ☐No

Was your child bottle-fed? ☐Yes ☐No If so, how long? _____

Is fluoride taken in any form? ☐Yes ☐No

Other information about your child's dental health or previous treatment _____

SIGNATURE _____ Relationship with Child _____

Date _____

